STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			-		
		007377	B. WING		06/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
INCARE H	OME HEALTHCARE INC	425 S JOL DYER, IN	IET ST STE 31: 46311	2	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
{N 000}	Initial Comments		{N 000}		
	This was a revisit for completed on March	the state complaint survey 11 - 18, 2014.			
	Substantiated: State	5226 and IN00145297 - deficiencies related to the Unrelated deficiencies are			
	Survey Date: May 28	3 - June 3, 2014			
	Facility #: 007377				
	Medicaid #: 20087325	50			
	Surveyor: Ingrid Mille Public Health	er, MS, BSN, RN I Nurse Surveyor			
		deficiencies were found deficiencies were recited. ies were cited.			
	Active patients on cer	nsus: 72 patients			
	Quality Review: Joyce June 13, 20	e Elder, MSN, BSN, RN 14			
{N 440}	410 IAC 17-12-1(a) H administration/manag	5	{N 440}		
		tive control, and lines of gation of responsibility down rel shall be: In writing; and			
		t as evidenced by: I Indiana State Department ument review and interview,			

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
					R-C	
		007377	B. WING		06/03/2014	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
INCARE H	OME HEALTHCARE INC	425 S JOLI DYER, IN	IET ST STE 31: 46311	2		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	J (X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	Ē
{N 440}	Continued From page	: 1	{N 440}			
		nsure the organizational ith the potential to affect all				
	Findings					
	 The agency's organizational chart, dated 4/1/14, evidenced the agency had a contracted Social Worker (MSW). The ISDH communication log with the agency stated, "5/11/12Received notification that agency no longer offering MSW services, eff. 5.2.12. To HP/OMPP/CMS" This communication had been from the agency to the ISDH. 					
	administrator / director social work was not p	AM, Employee A, the or of nursing, indicated art of the agency services. did have contracted MSW updated the state.				
N 444	410 IAC 17-12-1(c)(1 administration/manag		N 444			
	home health agency of time at the home heal as its administrator. also be the supervisir					
	This RULE is not me Based on clinical reco	_				

Indiana State Department of Health

STATE FORM 6899 4C3X12 If continuation sheet 2 of 82

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
711012711	or contraction	IDEITH IO/THOMBET	A. BUILDING: _		
		007377	B. WING		R-C 06/03/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	ORESS, CITY, STA	TE, ZIP CODE	
INCARE H	OME HEALTHCARE INC		IET ST STE 31	2	
		DYER, IN	46311		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
N 444	Continued From page	2	N 444		
	review, and interview, be knowledgeable ab organize and direct th 12 records (record #1 creating the potential 72 current patients.	review, other document , the administrator failed to out the agency's patients to the agency's functions for 7 of 4 - #18, #21, #22) reviewed to affect all of the agency's			
	The findings include				
	Regarding clinical rec	ord #14			
	services had been profor 9 weeks during the 12/10/13 - 2/7/14 and 2/18/14 and 3/7/14. The transferred to the hos returned home on 2/2 discharge had occurred had been discharged care had occurred whome. However, and assessment was com 2/26/14. The record win a file cabinet for cloevidence any discharghad been completed had been completed. patient had been discounted in a file cabinet for cloevidence any discharghad been completed. Patient had been discounted in a file cabinet for cloevidence any discharghad been completed. Patient had been discounted in a file cabinet for cloevidence any discharghad been completed. Patient had been discounted in a file cabinet for cloevidence any discharghad been completed. Patient had been discounted in a file cabinet for cloevidence any discharghad been completed. Patient had been discounted in a file cabinet for cloevidence any discharghad been completed. Patient had been discounted in a file cabinet for cloevidence any discharghad been completed. Patient had been discounted in a file cabinet for cloevidence any discharghad been completed. Patient had been discounted in a file cabinet for cloevidence any discharghad been completed in a file cabinet for cloevidence any discharghad been completed in a file cabinet for cloevidence any discharghad been completed in a file cabinet for cloevidence any discharghad been completed in a file cabinet for cloevidence any discharghad been completed in a file cabinet for cloevidence any discharghad been completed in a file cabinet for cloevidence any discharghad been completed in a file cabinet for cloevidence any discharghad been completed in a file cabinet for cloevidence any discharghad been completed in a file cabinet for cloevidence any discharghad been completed in a file cabinet for cloevidence and complete for cloevidence and comple	pital on 2/21/14 and 3/14. Neither a transfer or ed to show that the patient and then no resumption of een the patient returned basis start of care pleted by the RN on was kept as a closed record based records, but failed to ge assessment or summary for that a resumption of care It was not known that the harged. It was recommunity Healthcare 4 evidenced the patient had			
	been hospitalized from failing permacath. b. On 5/28/14 at	n 2/21/14 - 2/23/14 for a 7 PM, patient #14 indicated and that he / she had not			
		hange in the plan of care.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING		D 0
		007377	B. WING		R-C 06/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	-
INCAREL	OME HEALTHCARE INC	425 S JOLI	ET ST STE 312	2	
INCARE	OWE HEALTHCAKE INC	DYER, IN	46311		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
N 444	indicated no hospital had been completed a This was not following indicated the patient had had signed consective were no orders care provided. d. On 5/30/14 at indicated the patient had been transferred and returned home or resumption of care.	9:10 AM, Employee C transfer or discharge oasis at patient #14's end of care. It is policy. Employee C and signed the patient rights ent for a new start of care on a visited by the skilled nurse. It is and no plan of care for this and been discharged from was no discharge arge summary. The patient to the hospital on 2/21/13 in 2/23/14. There was no	N 444		
	and a diagnosis of dia plans of care for the control of care for 2/19/14 - 4/19/14 and of care for 2/19/14 - 4/19/14 by the physic the home health aide week for 9 weeks for The home health aide patient but had not turn December 2013. The but the concern was redocumented. a. On 5/29/14 at called by phone with IR present. Employee C was sent to patient	4/20/14 - 6/18/14. The plan /19/14 was signed on ian. This record evidenced was to visit two times a these certification period. had been visiting the rned in documentation since administrator was aware			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
					R-C	
		007377	B. WING		06/03/2014	4
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
INCARE H	OME HEALTHCARE INC	425 S JOL	IET ST STE 31:	2		
INOAKE I	OME HEAETHOAKE ING	DYER, IN	46311			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMP	(5) PLETE ATE
N 444	Continued From page	e 4	N 444			
N 444	caring for this patient Employee A indicated terminated earlier this date of termination. It is the patient. This is unconsultant." Employed I, registered nurse (Remployee A indicated progress in her work needs to make improving with her care of the prindicated that Employe home health aides we supervision of this aid with this care from the b. On 5/29/14 at indicated Employee Smonths ago and that seen her in the office	under the agency's care. I that Employee S had s year, but did not give a Employee A stated, "Why iis, I don't know. There is a the maintains contact with nder investigation with our ee A indicated that Employee N), is responsible for this. I that Employee I has made with the agency but still evement with documentation atients. Employee A ree I does supervise the ell and was in charge of de. The patient was pleased	N 444			
	indicated visiting patie weekend. Patient #19 services from Incare	5 was happy with the				
	indicated that she wa check on the services Employee C indicated had resigned. She or documentation had be the Employee S HHA investigate if Employee care for patient #15. patient was cognitivel Employee S was prove	een sent in for months from 's visits and she was to ee S was still doing personal Employee C indicated the ly aware and indicated				
		and spoke to writer and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		1 ' '	(X3) DATE SURVEY COMPLETED	
						R-C
		007377	B. WING		06	/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
INCARE HOME HEALTHCARE INC			IET ST STE 31:	2		
(VA) ID	SLIMMADY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 444	Continued From page	e 5	N 444			
	agency and caring for not turning in home h December 2013. She called her two weeks notes. This was the of the agency. She indi	dicated still working for the r patient #15. She indicated ealth aide visit notes since e indicated Employee A ago telling her to turn in her only patient that she saw for cated she was sorry she had is and asked if she was in				
	titled "Physician orde no physician signatur HHA - pt [patient] has	ument in clinical record #15 r" with a date of 2/1/14 and e stated, "D/C [discontinue] s private duty assistance cluded the signature of trator.				
	f. Three clinical documents were evidenced to be home health aide care plans and were dated on 12/18/13, 2/18/14, and 4/18/14.					
	Regarding clinical rec	cord #16				
	diagnosis of bronchiti the certification period was an active record. been transferred on 5 The patient was listed	, SOC 10/23/13 and a s, included a plan of care for d of 4/21/14 - 6/19/14 and However, the patient had 6/16/14 and then discharged. d on the active patients list r, the clinical record was				
	Healthcare, inc. Patie effective date of 5/28, name, medicare #, da 10/23/13 and certifica	tled "Incare Home ent Survey Census" with an /14 included patient #16's ate of birth, SOC date as ation period of 4/21/14 - bronchitis, and disciplines of				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		007377	B. WING		06/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		425 S JO	LIET ST STE 31:	2	
INCARE H	IOME HEALTHCARE INC	; DYER, IN	46311		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
N 444	Continued From page	e 6	N 444		
	indicated the discharg computer software pr	0:25 AM, Employee A ge was pending in the ogram called AXXESS, arning the features of the			
	Regarding clinical rec	cord #17			
	4. A document titled "Incare Home Healthcare, inc. Patient Survey Census" with an effective date of 5/28/14 included patient #17's name, medicare #, date of birth, SOC date as 2/2/14 and certification period of 4/3/14 - 6/1/14, diagnosis of benign hypertension, and disciplines of skilled nursing and home health aides.				
		12:15 PM, Employee C, the or, was unable to find patient			
		11:40 AM and at 1:10 PM, ble to find patient #17's			
	agency, Employee R, the discharged record health aide visit had of patient had been tran that date. There was	4 PM, the owner of the found the clinical record in ds. The patient's last home occurred on 4/29/14 and the effect to the hospital on no transfer or discharge ed in the clinical record.			
	Registered Nurse, inc transferred to the hos now discharged. No	4:30 PM, Employee I, dicated the patient had been spital on 4/29/14 and was transfer or discharge lary had been completed.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		COM	E SURVEY PLETED	
		007377	B. WING		I	R-C 6/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
INCARE H	IOME HEALTHCARE INC		OLIET ST STE 312 N 46311			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
N 444	administrator, indicat discharged and not a Regarding Clinical re	1:35 PM, Employee A, the ed the patient was active as indicated.	N 444			
	that patient #18's rec found. On 6/2/14 at record was located a summary and assess indicated patient #18	ord was not able to be 12:20 PM, Patient #18's nd had a discharge sment. The administrator 's record was complete.				
	neoplasm, included a certification period of payment source was plan of care indicated skilled nurse visits 1 and HHA visits for period showers 1 - 2 times a were also HHA visits 4/3/14, 4/9/14, 4/11/1 and 4/24/14 after the There was an aide care	, SOC 10/4/13 and and diagnosis of brain a plan of care for the 2/1/14 - 4/1/14. The listed as Medicare. This d the patient was to receive - 2 times weekly for 9 weeks				
	for the certification pe and payment source record were HHA vis name of patient #21	2, SOC 10/1/13 and a gia, included a plan of care eriod of 3/30/14 - 5/28/14 as Medicare. Included in the fits from record #21 with the documented. Ordered on the skilled nurse frequency				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
			A. BUILDING.		D.C.
		007377	B. WING		R-C 06/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	JE. ZIP CODE	
		425 S JO	LIET ST STE 31:		
INCARE H	OME HEALTHCARE INC	DYER, IN	46311		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
N 444	of 1 time a week for week x 9 weeks. HH-4/4/14, 4/8/14, 4/10/14/25/14, 4/29/14, 4/30 5/13/14, and 5/15/14, occurred on 3/25/14, 5/7/14, 5/14/14, and 5/15/14/14, and 5/15/14/14, and 5/15/14/14, and 5/15/14/14, and 5/15/14/14, 4/18/14, 4/22 5/2/14. On 6/3/14 at 1:05 indicated that she wa with patients #21 and not benefiting from the pay." 8. The agency policy documentation with may." 8. The agency policy documentation with may." 8. The agency policy documentation with may. This documentation with may in a completed by the direct by the skilled profess managing the patient there is an accurate managing the pat	9 weeks and HHA 2 times a HA visits occurred on 4/2/14, 4, 4/15/14, 4/17/14, 4/23/14, 0/14, 5/1/14, 5/7/14, 5/9/14, Skilled nurse visits 4/10/14, 4/23/14, 4/30/14, 5/21/14. HHA visits for in this record. These were tes: 4/9/14, 4/11/14, 2/14, 4/24/14, 4/30/14, and 5 PM, the administrator is looking into this situation #22. She stated, "We are is. [The patient] has private titled "Clinical no effective date stated, int each direct contact with cumentation will be ect caregivers and monitored ional responsible for 's care to ensure that ecord of the services conse and ongoing need for conformance with the plan of the plan, and vement documentation of on the plan of care will be ervice is rendered and clinical record within 7 days	N 444		
{N 458}	410 IAC 17-12-1(f) He administration/manag		{N 458}		
	Rule 12 Sec. 1(f) Pe	ersonnel practices for			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _	A. BUILDING:		
		007377	B. WING		R- 06/0	C 3/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
INCARE I	HOME HEALTHCARE INC	425 S JO DYER, IN	LIET ST STE 31: 46311	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
{N 458}	All employees caring be subject to Indiana registration required to service. Personnel redeliver home health so and shall include docthe job, including the (1) Receipt of job de (2) Qualifications. (3) A copy of limited IC 16-27-2. (4) A copy of current registration. (5) Annual performant This RULE is not me Based on personnel finterview, the agency personnel files contain competency skills evaluation as required in reviewed (S, U, X, Y) all the patients of the Findings 1. Employee S, home hire 8/10/07 and unknown failed to evidence an completed since 2012 2. Employee U, HHA patient contact in 2000 annual evaluation sin skills evaluation had Italiana and seminary in the subject of the subject to the subject of the	upported by written policies. for patients in Indiana shall licensure, certification, or to perform the respective ecords of employees who services shall be kept current umentation of orientation to following: escription. criminal history pursuant to at license, certification, or the evaluations. It as evidenced by: file and policy review and failed to ensure the ned annual evaluations, aluation, and a criminal 4 of 7 employee files with the potential to affect agency. The health aide (HHA), date of frown first patient contact, annual evaluation had been 2. In date of hire 4/9/09 and first 19, failed to include an ce 2010 and a competency of peen completed upon hire. Stered Nurse (RN), date of patient contact 4/10/14,	{N 458}			

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	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	:IED
		007377	B. WING		R-0 06/03	C 3/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
INIOA DE LI	OME HEALTHOADE IN	425 S JOL	IET ST STE 31:	2		
INCARE H	OME HEALTHCARE INC	DYER, IN	46311			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
{N 458}	Continued From page 10		{N 458}			
	patient contact 4/10/1 history completed on 5. The agency policy Evaluations" with no competency based per be conducted for all employment and at less 6. The agency policy with no effective date be established and many the personnel record criminal history and required by law."	r titled "Performance effective date stated, "A erformance evaluation will employees after 1 year of east annually thereafter." r titled "Personnel Records" stated, "Personnel files will laintained for all personnel I for an employee will include d background checks as				
{N 462}	410 IAC 17-12-1(h) H administration/manag		{N 462}			
	direct patient contact examination by a phy no more than one hur before the date that the	sician or nurse practitioner ndred eighty (180) days he employee has direct physical examination shall to ensure that the ead infectious or				
	This RULE is not me Based on personnel f interview, the agency	ile and policy review and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		007377	B. WING		R-C 06/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STAT	E, ZIP CODE	
INCARE H	IOME HEALTHCARE INC		LIET ST STE 312		
	OUR MARRY OT	DYER, IN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
{N 462}	Continued From page	e 11	{N 462}		
	than 180 days before employee files review	sical examination no more first patient contact in 2 of 7 ed (X and Y) with the he patients of the agency.			
	Findings				
		stered Nurse (RN), date of patient contact 4/10/14, physical examination.			
		date of hire 3/21/14 and first 4, failed to evidence a had been completed.			
	3. On 5/29/14 at 12:2 indicated the personn complete.	21 PM, Employee C, RN, el records were not			
	with no effective date having direct docume screening prior to pro Preemployment physi	titled "Health Screening" stated, "Each employee ntation of baseline health viding care to patients ical examination will be cian or nurse practitioner as w or agency policy."			
{N 470}	410 IAC 17-12-1(m) F administration/manag		{N 470}		
	procedures, the agen	t as evidenced by: a, interview, and review of cy failed to ensure staff had accordance to professional			

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	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			-		R-C	
		007377	B. WING		06/03/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ITE, ZIP CODE		
INCARE H	OME HEALTHCARE INC		LIET ST STE 31	2		
		DYER, IN	46311			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
{N 470}	Continued From page	2 12	{N 470}			
	standards in 2 of 2 ho (patient #19 and #20) potential to affect any Employee I, registere Employee E, home ho	completed creating the patients cared for by d nurse (RN), and				
	The findings include					
	1. On 6/2/14 at 2:10 PM, Employee E, HHA, was observed to place her supply bag on patient #19's couch without a barrier. 2. On 6/2/14 at 3:45 PM, Employee I, RN was observed to place her nursing bag on patient #20's bed. After using her stethoscope and blood pressure cuff to assess patient #20, she replaced these supplies in the bag without disinfecting them.					
	Evaluation - Supply B effective date stated, hung from chair. Barr Equipment cleaned p appropriate." 4. On 6/3/14 at 11:55	dure titled "Competency lag Technique" with no "Bag placed on surface or rier utilized, if appropriate rior to returning to bag, as				
	indicated the visits ab infection control stand					
N 484	410 IAC 17-12-2(g) C improvement	A and performance	N 484			
	to assure that their ef complement one and	n effective communications forts appropriately ther and support the ent's care. The means of				

Indiana State Department of Health

STATE FORM 6899 4C3X12 If continuation sheet 13 of 82

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		=1ED
					R-	С
		007377	B. WING		06/0	3/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
		425 S JO	LIET ST STE 31:	2		
INCARE F	IOME HEALTHCARE INC	DYER, IN	46311			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	COMPLETE DATE
N 484	Continued From page	e 13	N 484			
	documented in the ali	nical record or minutes of				
	case conferences.	nical record of minutes of				
	This RULE is not me	t as evidenced by:				
		ord review, interview, and				
		ency failed to ensure all				
		services documented the				
		vhile services were being				
	provided for 5 of 12 re	ecords reviewed (12, 15, 17,				
	21, and 22) with the potential to affect all agency					
	patients receiving mo	re than one service.				
	Findings:					
	Clinical record #12	start of care (SOC)				
		osis of benign hypertension,				
		e for the certification period				
	· ·	nd services of home health				
	aide services, skilled	nurse, and podiatrist. The				
	clinical record failed to	o show coordination of care				
		urse, the home health aide,				
	or the podiatrist.					
	On 5/20/14 at 10	:15 AM, Employee C				
		tion of care had occurred.				
	2. Clinical record #15	5, SOC 8/23/13 and a				
	diagnosis of diabetes	mellitus, included plans of				
		on periods of 2/19/14 -				
		6/18/14. The plan of care				
		was signed on 5/19/14 by				
		ervices ordered were home				
		d nurse services. This				
		home health aide was to				
		t for 9 weeks for these				
	•	The home health aide had				
		ent but had not turned in				
		December 2013. The are but the concern was not				
		nted. The record failed to				

Indiana State Department of Health

STATE FORM 4C3X12 If continuation sheet 14 of 82

Indiana State Department of Health

AND PLAN OF CORRECTION IDENTIFICATION NUMBER. A. BUILDING:	COMPLETED
007377 B. WING	R-C 06/03/2014
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CO	DE
425 S JOLIET ST STE 312	
INCARE HOME HEALTHCARE INC DYER, IN 46311	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE (ROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) (X5)
evidence coordination between the skilled nurse and home health aide. a. On 5/29/14 at 12:05 PM, Employee A was called by phone with Employee C and Employee R present. Employee A indicated Employee C was sent to patient #15's home to check if Employee S, HHA, was still caring for this patient under the agency's care. Employee A indicated that Employee S had terminated earlier this year, but did not give a date of termination. Employee A stated, "Why she never reported this, I don't know. There is a physician order, but she maintains contact with the patient. This is under investigation with our consultant." Employee A indicated that Employee I, RN, is responsible for this. Employee A indicated that Employee I had made progress in her work with the agency but still needed to make improvement with documentation with her care of the patients. Employee A indicated that Employee I does supervise the home health aides well and was in charge of supervision of this aide. The patient was pleased with this care from the agency. b. On 5/29/14 at 4:30 PM, Employee R indicated Employee S had resigned a couple of months ago and that no one from the agency had seen her in the office or at a visit with patient #15. c. On 5/29/14 at 4:50 PM, Employee C indicated visiting patient #15 over the past weekend. Patient #15 was happy with the services from Incare and the aide. Employee C indicated she was sent in by Employee A to check on the services of Employee S, HHA. Employee	

Indiana State Department of Health

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED	
INCARE HOME HEALTHCARE INC DYER, IN 46311 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) N 484 Continued From page 15 Employee S was still doing personal care for patient #15. Employee C indicated the patient was cognitively aware and indicated Employee S was providing HHA services. d. On 5/30/14 at 11:55 AM, Employee S was called via telephone and spoke to writer and Employee C. She indicated still working for the			007377	B. WING		I	-
INCARE HOME HEALTHCARE INC DYER, IN 46311 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) N 484 Continued From page 15 Employee S was still doing personal care for patient #15. Employee C indicated the patient was cognitively aware and indicated Employee S was providing HHA services. d. On 5/30/14 at 11:55 AM, Employee S was called via telephone and spoke to writer and Employee C. She indicated still working for the	NAME OF P	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) N 484 Continued From page 15 Employee S was still doing personal care for patient #15. Employee C indicated the patient was cognitively aware and indicated Employee S was providing HHA services. d. On 5/30/14 at 11:55 AM, Employee S was called via telephone and spoke to writer and Employee C. She indicated still working for the	INCARE I	HOME HEALTHCARE INC					
Employee S was still doing personal care for patient #15. Employee C indicated the patient was cognitively aware and indicated Employee S was providing HHA services. d. On 5/30/14 at 11:55 AM, Employee S was called via telephone and spoke to writer and Employee C. She indicated still working for the	PRÉFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
not turning in home health aide visit notes since December 2013. She indicated Employee A called her two weeks ago telling her to turn in her notes. This was the only patient she saw for the agency. She indicated she was sorry she had not turned in the notes and asked if she was in trouble. e. A document in clinical record #15 titled "Physician order" with a date of 2/1/14 and no physician signature stated, "D/C [discontinue] HHA - pt [patient] has private duty assistance since 12/13." This included the signature of Employee A, administrator. f. Three documents were evidenced to be home health aide care plans and were dated on 12/18/13, 2/18/14, and 4/18/14. 3. Clinical record #17, start of care 10/2/12 with a certification period of 4/3/14 - 6/1/14, included an order on the plan of care that stated, "Physician's order, 4/2/14, MSW [Master's of Social Work] eval [evaluation]" This was dated 4/2/14 and signed by Employee A, administrator and director of nursing, and not signed by the physician. The patient had a primary diagnosis of benign hypertension. The record failed to evidence coordination of care between the social worker or the nurse.	N 484	Employee S was still patient #15. Employee was cognitively aware was providing HHA set of the control of the co	doing personal care for the C indicated the patient the and indicated Employee S the provices. 11:55 AM, Employee S was and spoke to writer and dicated still working for the repatient #15. She indicated the ealth aide visit notes since the indicated Employee A ago telling her to turn in her only patient she saw for the did she was sorry she had not and asked if she was in the clinical record #15 titled in a date of 2/1/14 and no tated, "D/C [discontinue] private duty assistance cluded the signature of trator. In this were evidenced to be the plans and were dated on it did 4/18/14. In start of care 10/2/12 with a 4/3/14 - 6/1/14, included an are that stated, "Physician's was dated 4/2/14 and A, administrator and director gned by the physician. The diagnosis of benign cord failed to evidence	N 484			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		007377	B. WING		R-C 06/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	
INCARE H	OME HEALTHCARE INC		LIET ST STE 312		
	OLIMAN DV OT	DYER, IN		DDOVIDEDIO DI AN OF CODDI	TOTION
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLET
N 484	Continued From page	e 16	N 484		
	alternate administrato evaluation was not in	4:45 PM, Employee C, the or indicated the social work the record and that no care urred with the social worker			
	indicated the patient I worker. There was no communication to the	doctor or agency nurse all and need for the patient to			
	neoplasm, included a certification period of payment source was plan of care indicated skilled nurse visits 1 - HHA visits for persona 2 times a week for 9 v HHA visits documente 4/9/14, 4/11/14, 4/16/4/24/14 after the discourse an aide care plar no tasks for the home	and diagnosis of brain plan of care for the 2/1/14 - 4/1/14. The listed as Medicare. This I the patient was to receive 2 X weekly for 9 weeks and al care including showers 1 - weeks. There were also			
	not knowing he / she the home health ager not being aware of be	was receiving services from ncy. Patient #21 indicated eing discharged. There was on that showed the patient in the record.			
	diagnosis of parapleg for the certification pe and payment source	eriod of 3/30/14 - 5/28/14 as Medicare. Included in the ts from record #21 with the			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION		E SURVEY PLETED
		007377	B. WING			R-C 6/03/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
INCARE I	HOME HEALTHCARE INC		OLIET ST STE 312 N 46311			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
N 484	name of patient #21 this plan of care was of 1 time week for 9 week for 9 weeks. It 4/2/14, 4/4/14, 4/8/14 4/23/14, 4/25/14, 4/2 5/9/14, 5/13/14, and on 3/25/14, 4/10/14, 5/14/14, and 5/21/14 to patient #21 were awere from the followid 4/16/14, 4/18/14, 4/2 5/2/14. a. On 6/3/14 at registered nurse, ind the only one of patient home health aide set were used for patient he was the primary in conducting aide suped documentation of car record between the set of the was the primary in conducting aide suped documentation of car record between the set of the was the primary in conducting aide suped documentation of car record between the set of the was the primary in conducting aide suped documentation of car record between the set of the was indicated that she was with patients #21 and not benefiting from the pay." 6. The agency policy Patient services" with personnel furnishing liaison to assure that effectively and support the Plan of Care. The formal care conferen current Care plans a interaction Interdis-	documented. Ordered on the skilled nurse frequency weeks and HHA 2 times a HHA visits occurred on 4, 4/10/14, 4/15/14, 4/17/14, 9/14, 4/30/14, 5/1/14, 5/7/14, 5/15/14. SN visits occurred 4/23/14, 4/30/14, 5/7/14, . HHA visits documented as also in this record. These ng dates: 4/9/14, 4/11/14, 2/14, 4/24/14, 4/30/14, . 10:25 AM, Employee W, icated that patient #22 was nts #21 and #22 receiving rvices. Patient #21's visits the #22. Employee W indicated ourse visiting patient #22 and ervision. There was no recommunication in the services. 1:05 PM, the administrator as looking into this situation of the services. 1:05 PM, the administrator as looking into this situation of the patient 1 has private wittled "Coordination of the no effective date stated, "All services shall maintain a their efforts are coordinated on the objectives outlined in its may be done through ces, maintaining complete,	N 484			

Indiana State Department of Health

STATE FORM 4C3X12 If continuation sheet 18 of 82

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		· ,	E SURVEY PLETED
		007377	B. WING			R-C 5/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
INCARE H	OME HEALTHCARE INC		OLIET ST STE 312			
04015	CLIMMADY CT	·	N 46311	PROVIDER'S PLAN OF	CORRECTION	0.5
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 484	Continued From page	e 18	N 484			
	respond to changes i services, care, or goa conferences shall be patient's status and p	als Ongoing care conducted to evaluate the				
	Services" with no effective registered nurse a. F	Regularly reevaluates the				
N 486	410 IAC 17-12-2(h) C improvement	A and performance	N 486			
	, ,	ne home health agency shall s with other health or social wing the patient.				
	policy review, the age coordination of care of for 2 of 2 records revi services from anothe	ord review, interview, and ency failed to ensure occurred with other providers lewed of patients receiving r provider (14 and 16) with all agency patients receiving				
	Findings:					
	diagnosis of wound d patient was receiving skilled nurse services	1, SOC 8/12/13 with a isruption, evidenced the dialysis services along with the clinical record failed tion of care with the dialysis nurse.				
	a. On 5/28/14 at being on home hemo	7 PM, patient #14 indicated dialysis at SOC and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		007377	B. WING		l	R-C 6/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
INCARE H	IOME HEALTHCARE INC		LIET ST STE 312			
	CLIMMADY CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF COR	DECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
N 486	Continued From page	e 19	N 486			
	week until switching t a nearby dialysis facil Patient #14 indicated about this care receiv b. On 5/30/14 at	is at home three times a concturnal hemodialysis in ity in December 2013. telling the skilled nurse ed from a dialysis facility. 9:45 AM, Employee Concoordination of care noted in the skilled nurse and				
	a social work evaluati patient had refused. refusal did not discus order was refused an physician were aware	s, failed to evidence				
	licensed practical nur	10:30 AM, Employee CC, se, indicated the patient was health agency that provided				
	indicated the patient h	I1:05 AM, the administrator nad refused social work as no other documentation				
	Patient services" with personnel furnishing s liaison to assure that effectively and suppo the Plan of Care. Thi	titled "Coordination of no effective date stated, "All services shall maintain a their efforts are coordinated rt the objectives outlined in s may be done through ces, maintaining complete,				

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STATE FORM 4C3X12 If continuation sheet 20 of 82

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R-C	
		007377	B. WING		06/03/2014	
					1 00/00/2014	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
INCARE H	OME HEALTHCARE INC		LIET ST STE 312	2		
		DYER, IN	46311			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
N 486	Continued From page	e 20	N 486			
	current Care plans ar interaction Interdisc shall be conducted as respond to changes in services, care, or goal conferences shall be patient's status and put. The agency policy Services" with no efferegistered nurse a.	and written and verbal ciplinary care conferences is often as necessary to in the patient's needs, als Ongoing care conducted to evaluate the rogress." Ititled "Skilled Nursing ective date stated, "The Performs the initial Regularly reevaluates the				
{N 494}	410 IAC 17-12-3(a)(1)&(2) Patient Rights	{N 494}			
	Rule 12 Sec. 3(a) The patient or the patient's legal representative has the right to be informed of the patient's rights through effective means of communication. The home health agency must protect and promote the exercise of these rights and shall do the following: (1) Provide the patient with a written notice of the patient's right: (A) in advance of furnishing care to the patient; or (B) during the initial evaluation visit before the initiation of treatment. (2) Maintain documentation showing that it has complied with the requirements of this section.					
	records, and agency failed to ensure the paraintained for 3 of 12	and review of policy, clinical documents, the agency atient's right to dignity was 2 records reviewed (patient he potential to affect all 72				

Indiana State Department of Health

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED	
7.1.1.2	5. GG	BENTH TO THE OF THE BENTH WE	A. BUILDING: _		
		007377	B. WING		R-C 06/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
INCARE H	IOME HEALTHCARE INC		ET ST STE 312	2	
	I	DYER, IN	46311 		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{N 494}	Continued From page	21	{N 494}		
	Rights and Responsits stated, "The patient had signed the follows: the informed about the of any changes in the follows the patient I verbal, physical, and put the treated with dignity. 2. The agency admiss undated document titl and Responsibilities." 3. On 6/2/14 at 3:45 I having a complaint wi (HHA). The HHA had bath or having the behaving both tasks dor had only visited twice complained to the office asked to not have the had not been document that signed the care on 4/5/14. 4. On 6/3/14 at 7:45 I not knowing that the had not been the had not have the had signed the care on 4/5/14.	sion package contained an ed "Patient Bill of Rights PM, patient #20 indicated th a home health aide given him / her a choice of d made and not a choice of the The HHA, Employee D, The patient had ce about the care and aide return. This complaint ented in the complaint log. all record #20 evidenced the expatient rights at the start of the AM, patient #21 indicated the / she was receiving			
	the patient had signed 10/3/13.	d the patient rights on			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			_		R-C	
		007377	B. WING		06/03/20	14
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA			
INCARE H	OME HEALTHCARE INC	425 S JOLI DYER, IN 4	ET ST STE 31: 16311	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE CO	(X5) MPLETE DATE
{N 494}	Continued From page	22	{N 494}			
	indicated Employee T want [patient #22] to g to put [patient #22] in shower [the patient] w A review of clinic the patient had signed 10/1/13.	al record #22 indicated that d the patient rights on				
	6. The agency policy titled "Patient Bill of Rights and Responsibilities" with no effective date stated, "The patient has the right to exercise his or her rights as a patient of the home health agency as follows: the patient has the right to be informed about the care to be furnished, and of any changes in the care to be furnished as follows the patient has the right to be free from verbal, physical, and psychological abuse and to be treated with dignity."					
N 504	his or her rights as a agency as follows: (2) The patient has (D) Be informed about and of any changes in follows: (i) The home health patient in advance of (AA) disciplines that (BB) frequency of visit furnished. This RULE is not me Based on policy review	ent has the right to exercise patient of the home health the right to the following: but the care to be furnished, in the care to be furnished as agency shall advise the the: will furnish care; and sits proposed to be	N 504			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU	
7.1.12 . 2.11 .		is Livin (s) and the male a	A. BUILDING: _			
		007377	B. WING		R-0 06/03	C 3/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
INCARE H	OME HEALTHCARE INC	425 S JOL DYER, IN	IET ST STE 31: 46311	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
N 504	Continued From page	23	N 504			
	advance of any chang furnished in 3 of 12 re #22) with the potentia patients.	atient was informed in ges in the care to be ecords reviewed (#14, #21, I to affect all the agency's				
	Findings include					
	1. The agency policy titled "Patient Bill of Rights and Responsibilities" with no effective date stated, "The home health agency must protect and promote the exercise of these rights as follows the patient has the right to exercise his or her rights as a patient of the home health agency as follows the patient has the right to be informed about the care to be furnished and of changes in the care to be furnished the home health agency shall advise the patient in advance of disciplines that will furnish care, and the frequency of visits proposed to be furnished the home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice."					
		sion package contained a n led "Patient Bill of Rights				
	evidenced the patient rights at the start of ca	4, start of care 8/12/13, had received the patient are and was not aware of ces that occurred in March				
	that nursing services notice in early March filing a complaint with requested that Emplo	7 PM, patient #14 indicated were stopped without any 2014. Patient #14 indicated the office personnel and yee A, the administrator and vestigate the complaint.				

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indiana 0	tate Department of Tie	aili i				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
					_	
			D WING		R-	
		007377	B. WING		06/0	3/2014
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE		
TVAIVIL OF TH	TOVIDER OR OUT LIER					
INCARE H	OME HEALTHCARE INC		IET ST STE 31	2		
		DYER, IN	46311			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				22.10.2.101)		
N 504	Continued From page	e 24	N 504			
	. •					
	This never occurred o					
		s to the office and being told				
		ne patient needed to speak				
	to was Employee A.	At one call, the office staff				
	put the call on speake	er phone and patient #14				
	could hear Employee	A talking about not having				
	time to call patient #1	4 and complaining that the				
	patient called several	times. Employee A				
	indicated on the spea	ker phone her intentions to				
		occurring was done and at				
		eturn call, but she never did				
		er did investigate or resolve				
		nt. Patient #14 indicated				
	needing supplies for a					
	•	receive any more of these				
	_	ency staff stopped visits				
		ussing this failure to visit				
		nt #14 indicated being on				
		t the start of care with the				
	agency.					
		40.05.414.5				
		10:25 AM, Employee C,				
	-	N), indicated the patient was				
	not informed of the di	scharge.				
		AM, patient #21 indicated				
	_	was receiving services from				
		ncy. Patient #21 indicated				
	not being aware of be	eing discharged.				
	 a. A review of clir 	nical record #21 indicated				
	that the patient had si	igned the patient rights on				
	10/3/13.	-				
	b. On 6/3/14 at 1	10:25 AM, Employee W, RN,				
		#21 was not receiving the				
		d patient #22 received these				
	baths. This was done					
	indicated.	5 to convenience, ne				
	maioatoa.		1	I .		

Indiana State Department of Health

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		007377	B. WING		R-C 06/03/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
INCARE H	IOME HEALTHCARE INC		LIET ST STE 312	2	
		DYER, IN	46311		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
N 504	Continued From page	25	N 504		
	indicated that patient patients #21 and #22 services. Patient #22 patient #22. Employe primary nurse visiting aide supervision.	AM, Employee W, RN, #22 was the only one of receiving home health aide I's visits were used for be W indicated he was the patient #22 and conducting			
	-	e rights at the start of care			
	and Responsibilities" stated, "The home he and promote the exer follows the patient I or her rights as a patie agency as follows the informed about the changes in the care to health agency shall ac of disciplines that will frequency of visits pro	alth agency must protect cise of these rights as has the right to exercise his ent of the home health he patient has the right to e care to be furnished and of the befurnished the home divise the patient in advance furnish care, and the eposed to be furnished cry shall advise the patient blan of care, including			
N 505		n(D)(ii) Patient Rights ent has the right to exercise patient of the home health	N 505		
	agency as follows: (2) The patient has (D) Be informed abo and of any changes ir follows: (ii) The patient has the	the right to the following: ut the care to be furnished, the care to be furnished as e right to participate in the The home health agency			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND FLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING: _	A. BUILDING:		
		007377	B. WING		R-C 06/03/2	014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
INCARE H	OME HEALTHCARE INC		IET ST STE 312	2		
		DYER, IN	46311			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE C	(X5) COMPLETE DATE
N 505	Continued From page	26	N 505			
	shall advise the patier participate in planning (AA) The care or tre (BB) Changes in the This RULE is not me Based on policy revier interview, and clinical failed to ensure the prarticipated of any changes in 3 of 12 results.	nt in advance of the right to g the following: atment. e care or treatment.				
	Findings include					
	1. The agency policy titled "Patient Bill of Rights and Responsibilities" with no effective date stated, "The home health agency must protect and promote the exercise of these rights as follows the patient has the right to exercise his or her rights as a patient of the home health agency as follows the patient has the right to be informed about the care to be furnished and of changes in the care to be furnished the home health agency shall advise the patient in advance of disciplines that will furnish care, and the frequency of visits proposed to be furnished the home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice."					
	2. The agency admis document titled "Patie Responsibilities."	sion package contained a ent Bill of Rights and				
	evidenced the patient	4, start of care 8/12/13, had received the patient are and was not aware of				

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STATE FORM 4C3X12 If continuation sheet 27 of 82

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE	SURVEY LETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _	A. BUILDING:		LETED
		007377	B. WING			R-C /03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
INCAREL	IOME HEALTHCARE INC	425 S JOL	IET ST STE 312	2		
INCARE	IOME HEALTHCARE INC	DYER, IN	46311			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 505	Continued From page	e 27	N 505			
		ces that occurred in March				
	that nursing services notice in early March filing a complaint with requested that Emplo director of nursing inversion never occurred despire phone calls to the offi person that the patier Employee A. At one call on speaker phone Employee A talking all patient #14 and composite called several times. The speaker phone has meeting occurring was would return call, but and ever did investigate complaint. Patient #1 supplies for an abdomnot receive any more agency staff stopped discussing this failure Patient #14 indicated hemodialysis at the simple of the patient with discharge. 4. On 6/3/14 at 7:45 and knowing he / she the home health ager not being aware of b	ninal fistula dressing and did of these supplies when the visits without notice or to visit with her / him. being on home tart of care with the agency. 10:25 AM, Employee C, RN, was not informed of the AM, patient #21 indicated was receiving services from acy. Patient #21 indicated eing discharged.				
		nical record #21 indicated igned the patient rights on				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:		(X3) DATE SURVEY COMPLETED
			A. BUILDING		D.C.
		007377	B. WING		R-C 06/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
INCARE H	IOME HEALTHCARE INC		ET ST STE 312	2	
	Г	DYER, IN	46311 T		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
N 505	Continued From page	28	N 505		
	10/3/13.				
	indicated that patient	0:25 AM, Employee W, RN, #21 was not receiving the d patient #22 received these for convenience, he			
	5. On 6/3/14 at 10:25 AM, Employee W, RN, indicated that patient #22 was the only one of patients #21 and #22 receiving home health aide services. Patient #21's visits were used for patient #22. Employee W indicated he was the primary nurse visiting patient #22 and conducting aide supervision.				
	-	atient #22's file showed the e rights at the start of care			
	Rights and Responsite stated, "The home he and promote the exer follows the patient for her rights as a patient agency as follows to be informed about the changes in the care to health agency shall according of disciplines that will frequency of visits pro-	oposed to be furnished ocy shall advise the patient olan of care, including			
N 506	410 IAC 17-12-3(b)(2)(D)(iii) Patient Rights	N 506		
	Rule 12 (b) The patie	ent has the right to exercise			

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STATE FORM 4C3X12 If continuation sheet 29 of 82

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` '		l \ /	DATE SURVEY COMPLETED	
			A. Boilbillo.			R-C
		007377	B. WING			6/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
INCARE E	OME HEALTHCARE INC	425 S JC	LIET ST STE 312			
IIIOAILE I	TOME HEALTHOAKE INC	DYER, IN	V 46311			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
N 506	Continued From page	e 29	N 506			
	agency as follows: (2) The patient has (D) Be informed about and of any changes in follows:					
	interview, and clinical failed to ensure the p advance of any chan- furnished in 3 of 12 re	ew, agency document review, record review, the agency atient was informed in				
	Findings include					
	and Responsibilities" stated, "The home he and promote the exer follows the patient or her rights as a pati agency as follows be informed about the changes in the care thealth agency shall a of disciplines that will frequency of visits prothe home health agen	oposed to be furnished ncy shall advise the patient plan of care, including				
		ssion package contained a n led "Patient Bill of Rights				

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Indiana State Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING: _	A. BUILDING:		TIED
		007377	B. WING		R-0 06/0	C 3/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
INCARE	IOME HEALTHCARE INC	425 S JOL	LIET ST STE 31	2		
INCARE H	OME HEALTHCARE INC	DYER, IN	46311			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
N 506	Continued From page	30	N 506			
	and Responsibilities."					
	evidenced the patient rights at the start of ca the discharge of servi 2014.	4, start of care 8/12/13, had received the patient are and was not aware of ces that occurred in March				
	a. On 5/28/14 at 7 PM, patient #14 indicated that nursing services were stopped without any notice in early March 2014. Patient #14 indicated filing a complaint with the office personnel and requested that Employee A, the administrator and director of nursing, investigate the complaint. This never occurred despite patient #14's numerous phone calls to the office and being told that the person that the patient needed to speak to was Employee A. At one call, the office staff put the call on speaker phone and patient #14 could hear Employee A talking about not having time to call patient #14 and complaining that the patient called several times. Employee A					
	indicated on the spea call when the meeting that time she would re return a call and never the patient's complair needing supplies for a dressing and did not a supplies when the ag without notice or disco with her / him. Patien	ker phone her intentions to goccurring was done and at eturn call, but she never dider did investigate or resolve at. Patient #14 indicated				
		10:25 AM, Employee C, N), indicated the patient was scharge.				
	4. On 6/3/14 at 7:45	AM, patient #21 indicated				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R-C
		007377	B. WING		06/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
		425 S JO	LIET ST STE 312	2	
INCARE F	IOME HEALTHCARE INC	DYER, IN	46311		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
N 506	Continued From page	: 31	N 506		
	the home health agen not being aware of be a. A review of clir	nical record #21 indicated			
	10/3/13.	gned the patient rights on			
	indicated that patient	10:25 AM, Employee W, RN, #21 was not receiving the d patient #22 received these e for convenience, he			
	indicated that patient patients #21 and #22 services. Patient #2 patient #22. Employe	6 AM, Employee W, RN, #22 was the only one of receiving home health aide I's visits were used for the W indicated he was the patient #22 and conducting			
		nt #22's file showed the e rights at the start of care			
	and Responsibilities" stated, "The home he and promote the exer follows the patient or her rights as a patie agency as follows the informed about the changes in the care to	alth agency must protect cise of these rights as has the right to exercise his ent of the home health he patient has the right to e care to be furnished and of the befurnished and of the befurnished and of the core to be furnished and the core to be			
	of disciplines that will frequency of visits pro	pposed to be furnished acy shall advise the patient			

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STATE FORM 4C3X12 If continuation sheet 32 of 82

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND FLAN C	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPLET	EU
		007377	B. WING		R-C 06/03/	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
INIOA DE LI	OME HEALTHOADE INO	425 S JOL	IET ST STE 312	2		
INCARE H	OME HEALTHCARE INC	DYER, IN	46311			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
N 506	Continued From page	e 32	N 506			
	reasonable discharge	notice."				
N 508	410 IAC 17-12-3(b)(2)(E) Patient Rights	N 508			
	her rights as a patient as follows: (2) The patient has (E) Confidentiality of maintained by the horomen health agency sthe agency's policies disclosure of clinical rolls. This RULE is not me Based on policy reviews	the right to exercise his or t of the home health agency the right to the following: of the clinical records me health agency. The shall advise the patient of and procedures regarding records. It as evidenced by: w and text and document				
	the patient's right to c information had been shared her password information with anoth	the agency failed to ensure onfidential clinical record protected when employee I to access clinical ner person for 1 of 1 agency to affect all of the agency's				
	The findings include:					
	privacy rights will be p the time of admission Rights to inform pa rights of privacy. To a privacy rights as spec the Health Information regulation."	ive date stated, "Patient presented to all patients at with the Home Care Bill of tients of the agency of their accommodate patient cified in the privacy rule of and Accountability Act				
	2. These are text excl	hanges from the				

Indiana State Department of Health

STATE FORM 6899 4C3X12 If continuation sheet 33 of 82

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		007377	B. WING		I	R-C 03/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
INCARE H	OME HEALTHCARE INC	425 S JO DYER, IN	LIET ST STE 31: 46311	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
N 508	a. On 4/1/14 at 6 texted to Employee I, errors in your cert for b. From Compla PM, "That's not the right of	byee I, Registered Nurse. 6:33 PM unknown person "Please call me. You have [patient #7]" inant to Employee I at 7:45 ght password." ee I at 7:50 PM, [password mant at 7:50 PM, " Thank 12:14 PM, From byee I, " Are going to be boday?" PM, Employee I wrote her in an envelope. (This assword noted in the .) PM, Employee I indicated the one. She indicated she swords with Employee A, the	N 508			
{N 514}	410 IAC 17-12-3(c) P	·	{N 514}			
	the patient's family or regarding either of the	plaints made by a patient or legal representative				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDILAN	or domined hold	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:		
		007377	B. WING		R-0 06/0	C 3/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
INCARE H	OME HEALTHCARE INC	425 S JOI DYER, IN	LIET ST STE 31: 46311	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
{N 514}	by anyone furnishing home health agency. (2) Document both a complaint and the result and the result and resolut the agency failed to foinvestigate complaint existence and resolut the patients service and resolut the patient has a patient of the patient has a patient of the patient has a patient of the patient and resolut the patient and resolutions at the start of careful and the patient rights at the start of careful and resolutions.	sect for the patient's property services on behalf of the the existence of the solution of the complaint. It as evidenced by: W, clinical record review, ent review, and interview, ollow their own policy to and document the ion of the complaint for 5 of with the potential to affect yed by the agency. (#12, 14, which is the home health of the home health agency as has the right to exercise his ent of the home health agency as has the right to place a partment regarding hished by a home health in mplaints about care or nization investigates the ion of the same." It is ion package contained and ided "Patient Bill of Rights in the total patient and failed to have a did, investigated, or resolved.	{N 514}			

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STATE FORM 6899 4C3X12 If continuation sheet 35 of 82

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		007377	B. WING		R-C 06/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	
INCARE H	IOME HEALTHCARE INC		LIET ST STE 312		
	Г	DYER, IN	I 46311		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
{N 514}	Continued From page	35	{N 514}		
	having a complaint th by the administrator. of not receiving aide v of care. 4. Clinical record #1	23 PM, the patient indicated at had not been addressed The patient had complained visits as ordered on the plan 4, start of care 8/12/13, had received the patient			
	rights at the start of ca	are and failed to have a d, investigated, or resolved.			
	that nursing services notice. Patient #14 in with the office person Employee A, the adm nursing, investigate the occurred despite paties calls to the office and that the patient needs Employee A. At one call on speaker phone Employee A talking all patient #14 and composalled several times. The speaker phone he meeting occurring was would return call, but and never did investig complaint. Patient #1 supplies for an abdom not receive any more agency staff stopped discussing this failure Patient #14 indicated	call, the office staff put the e and patient #14 could hear pout not having time to call plaining that the patient Employee A indicated on er intentions to call when the s done and at that time she she never did return a call gate or resolve the patient's 4 indicated needing hinal fistula dressing and did of these supplies when the visits without notice or to visit with her / him.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING	A. BOILBING.		
		007377	B. WING	B. WING		R-C /03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	FE, ZIP CODE		
INCARE H	IOME HEALTHCARE INC	425 S JO DYER, IN	LIET ST STE 312 46311	!		
(VA) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CO	APPECTION!	(V5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
{N 514}	Continued From page	e 36	{N 514}			
		10:25 AM, Employee C, licated the complaint had complaint log.				
	received the patient ri had not had a compla	ved. The complaint log				
	complained that the p and canceled and had occur that weekend. patient indicated calling	D PM, patient #19 shysical therapist had called d said that a visit would No visit had occurred. The ng the office and no follow- up had occurred.				
	having a complaint wi (HHA). The HHA had bath or having the be having both tasks dor had only visited twice complained to the offi asked to not have the	PM, patient #20 indicated ith a home health aide I given him / her a choice of d made and not a choice of he. The HHA, Employee D, The patient had ce about the care and aide return. This complaint ented in the complaint log.				
		al record #20 evidenced the e patient rights at the start of				
	evidenced the patient rights at the start of care	, start of care 10/1/13, had received the patient are and failed to have a d, investigated, or resolved. ed to evidence the				
		AM, the power of attorney for mal caregiver of patient #22				

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STATE FORM 6899 4C3X12 If continuation sheet 37 of 82

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		007377	B. WING			R-C 6/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
INCARE H	OME HEALTHCARE INC		OLIET ST STE 312 N 46311			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
{N 514}	that the patient was r not showers that had indicated receiving not complaint. In Februal also complained and plan of care was alter that he /she should be follow up with this con attorney indicated last administrator about the showers as requested. 8. A review of the con- evidence any investige documentation conceptation of the con- patient #12, #14, #19	ployee A with a complaint ecciving sponge baths and been agreed upon. He/she of follow up with his ary, the power of attorney had requested that any time the red or days were changed e contacted. There was no implaint. The power of st week to talk to the ne patient not receiving d and getting no response. Implaint log failed to gation or other erning the complaint filed by 1, #20, #22.	{N 514}			
{N 520}	care on the basis of a that the patient's hearmet by the home hear place of residence. This RULE is not me Based on agency door record review, policy agency failed to ensuraddressed and being agency in the patient' 12 patient records (13)	atients shall be accepted for a reasonable expectation a reasonable expectation at the needs can be adequately alth agency in the patient's at as evidenced by: cument review, clinical review, and interview, the are patients needs were met adequately by the as place of residence in 6 of 2, 14, 16, 17, 19, 22) as potential to affect all y.	{N 520}			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			7.1. 20122			2.0
		007377	B. WING			R-C /03/2014
		00.011			1 00	03/2014
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
INCARE H	OME HEALTHCARE INC		OLIET ST STE 312			
	I	DYER, II	N 46311			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
{N 520}	Continued From page	e 38	{N 520}			
	orders for home healt	olan of care for the 4/21/14 - 6/19/14 with th aide (HHA) 1 - 2 times a owever, no visits occurred				
	indicated having a co- addressed by the adn complained of not rec	4:23 PM, the patient mplaint that had not been ninistrator. The patient had eviving aide visits as ordered and not having his / her needs				
	evidenced the patient rights at the start of ca					
	that nursing services notice in early March filing a complaint with requested that Emplo director of nursing, in This never occurred conumerous phone calls the person the patient Employee A. At one call on speaker phone Employee A talking all patient #14 and comp called several times.	7 PM, patient #14 indicated were stopped without any 2014. Patient #14 indicated the office personnel and yee A, the administrator and vestigate the complaint. despite patient #14's so to the office and being told to needed to speak to was call, the office staff put the e and patient #14 could hear cout not having time to call obtaining that the patient Employee A indicated on er intentions to call when the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R-C
		007377	B. WING		06/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
INICADE I	IOME HEALTHOADE IN	425 S JO	LIET ST STE 312	2	
INCARE F	OME HEALTHCARE INC	DYER, IN	I 46311		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLET
{N 520}	would return call, but and ever did investiga complaint. Patient #1 supplies for an abdon not receive any more agency staff stopped discussing this failure Patient #14 indicated hemodialysis at the sib. On 5/29/14 at indicated the patient. 3. Clinical record #16 diagnosis of bronchiti the certification period failed to evidence the met. The patient had Evaluation ordered or to evidence that the patient's refusal for the community resources patient. No social wor The director of nursin write any notes in this a. On 4/10/14 at	s done and at that time she she never did return a call ate or resolve the patient's 4 indicated needing in inal fistula dressing and did of these supplies when the visits without notice or to visit with her / him. being on home tart of care with the agency. 10:25 AM, Employee C, RN, is needs had not been met. 3, start of care 10/23/13 and is, included a plan of care for d of 4/21/14 - 6/19/14 which patient's needs had been a Social Worker (MSW) in 4/21/14. The record failed only sician was notified of the esocial work visit. No is were made available to the rick interventions occurred. If you was contacted and did not is clinical record. 6:52 PM, the home	{N 520}	DEFIGIENCT)	
	safe living situation. V patient needs place in	e a more appropriate and Vill order social services n a skilled facility cannot			
	practical nurse (LPN) clinical note, "Will cor regarding living condi	." 5:15 PM, the licensed , Employee C, stated in a stact SS [Social Services tions]." This did not occur. written by Employee W,			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
					 R-	C
		007377	B. WING		1	3/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
INCARE H	OME HEALTHCARE INC	425 S JOLII Dyer, in 4	ET ST STE 312	2		
(Y4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N I	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETE DATE
{N 520}	Continued From page	. 40	{N 520}			
{N 520}	registered nurse (RN) under Care coordination of nursing, "Patient new MD for possible assist placement. Need for frequency for SN [skill to be increased. MD nursing] to see patient of the desire of	on to Employee A, director seeds evaluation by home ted living or nursing home MSW also relayed. Current led nurse] and HHA needs and DON [director of this PM." 11:05 AM, the administrator nad refused social work as no documentation about his refusal occurred. 11:30 AM, a clinical note W, Registered Nurse, seessment lethargic but diffied for ambulance transfer." Patient was transferred 15:05 AM, a clinical note N, Registered Nurse, seessment lethargic but diffied for ambulance transfer. This was transferred 16:05 AM, a clinical note N, Registered Nurse, seessment lethargic but diffied for ambulance transfer. This was transferred 16:05 AM, a clinical note N, Registered Nurse, seessment lethargic but diffied for ambulance transfer and the stated, "Physician's eval [evaluation]" This was need by Employee A, ector of nursing, and not an. 16:05 AM, the administrator nad refused hours and the patient had fallen but self on arms on 4/29/14 are E, the home health aide, and employee I called the I did not write any notes on not write a transfer oasis. An	{IN 52U}			
	with a knife. Employed called with an update physician. Employee this incident and did not informal caregiver too	ee E, the home health aide, and employee I called the I did not write any notes on not write a transfer oasis. An k the patient to the are the patient was admitted				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 50.2540.		D 0
		007377	B. WING		R-C 06/03/2014
NAME OF D	DOVIDED OD SUDDIJED	CTDEET AS	DDRESS, CITY, STA	TE ZID CODE	
NAME OF P	ROVIDER OR SUPPLIER		, ,	,	
INCARE H	OME HEALTHCARE INC	DYER, IN	LIET ST STE 31: 46311	2	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
{N 520}	Continued From page	41	{N 520}		
	alternate administrato evaluation was not in c. On 6/3/14 at 1 indicated the patient hworker. There was not communication to the 5. Clinical record #19, received the patient rihad not had a complainvestigated, or resolv	:30 PM, Employee A had refused to see a social order or other doctor about this refusal. start of care 4/5/2014, had ghts at the start of care and int documented, red.			
	and canceled and had occur that weekend. patient indicated callir	I said that a visit would No visit had occurred. The			
	rights at the start of ca complaint documente	start of care 10/1/13, had received the patient are and failed to have a d, investigated, or resolved. M, the power of attorney for			
	patient #22 and informindicated calling Employers the patient was received showers that had been indicated receiving not complaint. In February also complained and plan of care was alternated that he /she should be follow up with this contact attorney indicated last administrator about the	nal caregiver of patient #22 oyee A with a complaint that ing sponge baths and not n agreed upon. He/she follow up with his y, the power of attorney had requested that any time the ed or days were changed e contacted. There was no nplaint. The power of			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		007377	B. WING			R-C 5 /03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE	-	
INCARE H	IOME HEALTHCARE INC		OLIET ST STE 312 N 46311			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
{N 520}	Continued From page	e 42	{N 520}			
	patient #12, #14, #19 9. The agency policy Process" with no effe agency cannot fulfill treferral will be made community resources notified." 10. The agency docu Rights and Responsil stated, "Be admitted care you need."	gation or other erning the complaint filed by , #20, #22. titled "Patient Admission ctive date stated, "If the he required health need, a to other appropriate and referral source will be ment titled "Patient Bill of bilities" with no effective date only if we can provide the				
{N 522}	written medical plan of periodically reviewed	Patient Care edical care shall follow a of care established and by the physician, dentist, rist or podiatrist, as follows:	{N 522}			
	and interview, the ago services and treatme accordance with phys records reviewed (#7	ord and agency policy review				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
			D WING		l l	k-C	
		007377	B. WING		06/	03/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE			
INCARE I	IOME HEALTHOADE INO	425 S JC	LIET ST STE 312				
INCARE F	IOME HEALTHCARE INC	DYER, II	N 46311				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
{N 522}	Continued From page	: 43	{N 522}				
	Findings						
	with a diagnosis of Co included a plan of car of 3/23/14 - 5/21/14 w therapy (OT) visits. T frequency for the visit 3/25/14, 3/27/14, 4/3/ Skilled nurse visits we of care. A nurse visit show that the nurse h ordered on the plan o for edema and periph failed to complete a b	start of care (SOC) 7/26/13 ongestive Heart Failure, e for the certification period vith orders for occupational the orders failed to include s which occurred on 14, 4/8/14, and 4/10/14. ere also ordered on the plan on 4/11/14 at 9 AM, failed to ad completed the tasks f care including assessing eral circulation. The nurse ody system assessment e nurse failed to complete a					
		55 PM, Employee C, N) indicated the visits above n of care.					
	diagnosis of benign h plan of care for the ce - 6/19/14 on 5/29/14 a 10 AM, the clinical rec care for the certification 6/19/14. This plan of nurse was to visit the weeks to assess pain shortness of breath, v instruct on pain mana mechanics and safety proper foot wear whe encourage the patient skilled nurse visits we	care evidenced the skilled patient 1 times a week for 9 level, instruction on weekly weights, assess and gement, proper body measures, to instruct on					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		007377	B. WING		R-C 06/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	TE, ZIP CODE	
INCAREL	OME HEALTHCARE INC	425 S JO	LIET ST STE 312	:	
INCARE	OME REALITICARE INC	DYER, IN	46311		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
{N 522}	1 0	e 44 risit notes in the record were	{N 522}		
	on 5/14/14 and 5/16/1	4. No other aide notes current certification period.			
	indicated the plan of completed and was n	ot part of the clinical record s and home health aide			
	registered nurse (RN) piece of paper with vismonths noted on this did not document the This paper was divide vital signs and the darpaper did not indicate care had been complete.	2:00 PM, Employee I, was observed to have a sit notes for the past two paper. She indicated she visit until later at home. d into about 8 sections and the were recorded. The what part of the plan of eted besides vital signs. sessments or instructions oted.			
	the skilled nurse visits record and document a visit note or in the s nurse visits used by the indicated Employee I	PM, Employee A indicated as were missing from the ation of a visit should be on oftware program for skilled the agency. Employee A had not been documenting as timely or according to			
	plan of care for the ce - 5/27/14 that was ele Employee I on 3/25/1 plan of care on 5/10/1 made on 4/15/14, 4/2 5/17/14, 5/20/14, and	s, SOC 3/29/14, evidenced a ertification period of 3/29/14 ctronically signed by 4. The physician signed this 4. Skilled nurse visits were 22/14, 4/29/14, 5/9/14, 5/27/14. There was no urse visits on this plan of			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPLETED
					R-C
		007377	B. WING		06/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		425 S JOL	ET ST STE 312		
INCARE F	OME HEALTHCARE INC	DYER, IN	46311		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{N 522}	Continued From page	: 45	{N 522}		
	indicated the skilled n plan of care. 4. Clinical record #14 disruption evidenced occurred on 8/12/13 a	25 PM, Employee C urse had not followed the with a diagnosis of wound two starts of care. One and the other on 2/26/14. I a plan of care for the			
	certification period of was signed on 1/16/1 of care after this certif no orders for skilled n documented on 2/18/	12/10/13 - 2/7/14, which 4. There was no other plan fication period. There were urse visits which were 14 and 3/7/14. An oasis ent was completed by the			
	On 5/30/14 at 9:45 AM, Employee C indicated there were no orders on the plan of care for the skilled nurse visits that occurred on 2/18/14 and 3/7/14 and the oasis start of care assessment completed by the RN on 2/26/14.				
	care for the certification 2-18-14 (HHA to visit skilled nurse 1 - 2 times 4/19/14 (HHA 2 times (SN) 1 times a week) one times a week). T	, SOC 8/23/13 and a mellitus, included plans of on periods of 12-21-13 - 1 - 2 times a week and es a week), 2/19/14 - a week and skilled nurse and 4/20/14 - 6/18/14 (SN he plan of care for 2/19/14 - n 5/19/14 by the physician.			
	The home health aide patient but had not turn December 2013. The but the concern was redocumented. Home I made since December documentation in the	e had been visiting the rned in documentation since administrator was aware not corrected or nealth aide visits had been			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING		
		007377	B. WING		R-C 06/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
INCADE L	OME HEALTHCARE INC	425 S JOL	IET ST STE 312	2	
INCARE	IOWE HEALTHCARE INC	DYER, IN	46311		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULING CROSS-REFERENCED TO THE APPROFE DEFICIENCY)	D BE COMPLETE
{N 522}	Continued From page	÷ 46	{N 522}		
	The patient had physi occupational therapy and 5/8/14 and these	t tasks were performed. cal therapy and visits ordered on 4/20/14 visits did not occur. There n in the record why these			
	called by phone with IR present. Employee C was sent to patient Employee S, HHA, wa under the agency's cathat Employee S had but did not give a date A stated, "Why she ne know. There is a phy maintains contact with investigation with our indicated that Employe this. Employee A indimade progress in her still needs to make im documentation with h Employee A indicated supervise the home h charge of supervision	n the patient. This is under consultant." Employee A ee I, RN, is responsible for cated that Employee I has work with the agency but			
	indicated Employee S months ago and that	4:30 PM, Employee R had resigned a couple of no one from the agency had or at a visit with patient #15.			
	indicated visiting patie weekend. Patient #19 services from Incare a indicated that she was				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING	,ssss	
		007377	B. WING		R-C 06/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE	
INCAREL	IOME HEALTHCARE INC	425 S JOI	LIET ST STE 312		
INCARE	IOME HEALTHCARE INC	DYER, IN	46311		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETE
{N 522}	Employee S had resigned documentation had be the Employee S HHA investigate if Employee care for patient #15. patient was cognitived Employee S was proved. On 5/30/14 at called via telephone as Employee C. She into for the agency and called to turning in notes since December Employee A called he to turn in her notes. saw for the agency. She had not turned in was in trouble. e. On 5/30/14 at indicated the plan of the therapy visits never the document of the therapy visits never the Employee A called here to turn in her notes. Saw for the agency. She had not turned in was in trouble.	d not knowing that the gned. She only knew that no een sent in for months from the visits and she was to see S was still doing personal Employee C indicated the ly aware and indicated viding HHA services. 11:55 AM, Employee S and spoke to writer and dicated she was still working aring for patient #15. She in home health aide visit er 2013. She indicated er two weeks ago telling her This was the only patient she She indicated she was sorry the notes and asked if she at:10 PM, Employee C care was not followed and	{N 522}		
	HHA - pt [patient] has	private duty assistance cluded the signature of			
		documents in the record le care plans and were 18/14, and 4/18/14.			
	diagnosis of bronchiti nurse used triple antil	5, start of care 10/23/13 and s, evidenced the skilled biotic ointment on the without obtaining an order			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		007377			R-C 06/03/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
INCARE HOME HEALTHCARE INC			LIET ST STE 312	2		
		DYER, IN	I 46311		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
{N 522}	Continued From page	2 48	{N 522}			
	where the skin tear w On 6/2/14 at 11:2	M. It was not documented as. 20 AM, Employee A, the ed there was no order for				
	of 4/17/14 - 6/15/14.	ve chronic bronchitis, e for the certification period The record failed to nad received the physical				
	On 6/3/14 at 2 PI these visits did not oc	M, Employee A indicated ccur.				
	a plan of care for the - 6/3/14, evidenced of treatment and OT evan These visits had not consistent on 5/5/14 and	airway obstructive, included certification period of 4/5/14 rders for PT evaluation and aluation and treatment.				
	administrator, indicate	5 PM, Employee A, the ed they had been locked out d could not access patient				
	with no effective date care is developed for admission and signed appropriate time fram include prompt report	titled "Medical Supervision" stated, "A physician plan of each patient at the time of by the physician in the e agency responsibilities ing of a change in patient of a physician plan of care."				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDILAN	or dorace from	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:		
		007377	B. WING		R-C 06/03	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
INCARE H	OME HEALTHCARE INC	425 S JOLI	ET ST STE 31	2		
		DYER, IN	46311	T		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
{N 522}	Continued From page	e 49	{N 522}			
	with no effective date services that are in corprofessional standard Industry as well as the identified agency performance of the plan of care estable agency staff will deliving patient's unique and in the plan of care estable agency staff will deliving patient's unique and in the plan of care estable agency staff will deliving patient's unique and in the physician. The plan of comprehensive assess provided by the patient members The plan of comprehensive assess provided by the patient members The plan of care in the plan of care in the patient's condition time every 60 days. In physician to any channal ter the plan of care is hall be obtained from	e state and federal laws and formance improvement lare will be provided under slished by a physician er services based on each individual needs." Ty titled "Plan of Care" with ed, "Home care services are upervision of the patient's of care is based on a sement and information in the patient had be consistently at the patient needs are necessary at least every 60 and personal care for each patient in and personal care if care shall be completed in frequency, and duration of nedications, treatments, ent goals signed physician ed by the attending physician ed by the attending physician ed by the attending physician ed as often as the severity of a requires, but at least one Professional staff alert the ages that suggest a need to Verbal telephone orders in the patient's physician for				
{N 524}	changes in the plan o		{N 524}			
	Rule 13 Sec. 1(a)(1)	As follows, the medical plan				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
007377				R-C	
		007377	B. W. C		06/03/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	
INCARE H	OME HEALTHCARE INC		LIET ST STE 312	2	
		DYER, IN	46311		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
{N 524}	health agency staff. (B) Include all service service is being provice (B) Cover all pertiner (C) Include the follow (i) Mental status. (ii) Types of service (iii) Frequency and (iv) Prognosis. (v) Rehabilitation policy (vi) Functional limitation policy (vii) Activities permitation (viii) Activities permitation (viii) Activities permitation (viii) Medications and (x) Any safety meaning (x) Instructions for (xii) Therapy modality treatment. (xiii) Any other approximation of care was sign and included all requirecords reviewed (#7 with the potential to a patients. Findings 1. Clinical record #7, with a diagnosis of Colors.	es to be provided if a skilled ded. Int diagnoses. Ving: es and equipment required. duration of visits. otential. ations. tted. rements. d treatments. asures to protect against timely discharge or referral. ties specifying length of priate items. t as evidenced by: ord review, policy review, ency failed to ensure the ed by the physician timely red elements for 8 of 12 12, 13, 14, 15, 16, 17, 19) ffect all the agency's start of care (SOC) 7/26/13 ongestive Heart Failure,	{N 524}		
	•	re for the certification period nat was not signed by the			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:		
		007377	B. WING		R-C 06/03/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
INCARE H	OME HEALTHCARE INC		IET ST STE 312	2		
		DYER, IN	46311 			_
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	E
	period of 5/22/14 - 7/2 completed on 5/30/14 included orders for or lacked frequency and medication list on the certification periods lamedications were give medications including hydrocodone with Tylea. On 5/30/14 at Registered Nurse (RN was not completed by plan of care for the certification sincluding hydrocodone with Tylea.	at 3 PM. The plan of care ccupational therapy, but they duration of the visits. The plan of care for these acked the reason the en for the as needed polyethylene glycol and enol. 2:55 PM, Employee C, N), indicated the plan of care of the physician and the new entification period was not national therapy orders				
	indicated the plan of certification period was 2. Clinical record #12 diagnosis of benign h the physician had sign certification period of 6/1/14. This plan of cof the as needed mechydrocodone / acetan (milligrams) every 6 - ambien 5 mg oral tab Additionally, the ambimany tablets a day w time of day the medical a. On 5/29/14 at indicated the plan of a timely manner.	ninophen 10 - 325 mg 8 hours as needed and let prn po (by mouth). en did not evidence how ould be given and at what				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING		D.C.
		007377	B. WING		R-C 06/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE	
TO AVIC OF T	NOVIDER ON OUT FEEL		LIET ST STE 31		
INCARE H	IOME HEALTHCARE INC	DYER, IN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
{N 524}	Continued From page indicated the plan of omedications listed cord. 3. Clinical record #13 diagnosis of chronic profession of the certification peand also for 5/28/14 evidence a complete patch was listed withor oute of administration 5/28/14 - 7/26/14 evidences of pain in pain management the nurse was to instruct medication before better pain control. To pain assessments or care to measure the diagraphic medicated the medicated the medicated the medicated to include the diadministration for the that no measurable gothe patient's pain lever teaching with pain cord. 4. Clinical record #14 disruption evidenced occurred on 8/12/13 and The record evidenced certification period of not signed by the phy was no other plan of operiod. There were not the signed signed by the phy was no other plan of operiod. There were not signed by the phy was no other plan of operiod. There were not signed by the phy was no other plan of operiod. There were not signed by the phy was no other plan of operiod. There were not signed by the phy was no other plan of operiod. There were not signed by the phy was no other plan of operiod. There were not signed by the phy was no other plan of operiod. There were not signed by the phy was no other plan of operiod. There were not signed by the phy was no other plan of operiod.	care did not have the crectly. 3, SOC 9/30/13 with a pain, included a plan of care riod of 3/29/14 - 5/27/14 7/26/14 which failed to medication list. Fentanyl put the dose, frequency, or an	{N 524}		
	3/7/14. An oasis start completed by the RN				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		007377	B. WING		R-C 06/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
INCARE H	OME HEALTHCARE INC	425 S JOL DYER, IN	IET ST STE 31: 46311	2	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
{N 524}	Continued From page	53	{N 524}		
	there was no plan of ovisits that occurred on oasis start of care ass RN on 2/26/14. 5. Clinical record #15, diagnosis of diabetes care for the certification 2-18-14 (HHA to visit skilled nurse 1 - 2 times week) and 4/20/14 - 6 week). The plan of care was not signed until 5 A clinical docume titled "Physician order no physician signature HHA - pt [patient] has since 12/13." This independent of the certification period plan of care was not signed. 6. Clinical record #16 diagnosis of bronchitist the certification period plan of care was not signed. 7. Clinical record #17 certification period of evidence the frequency nurse visits which occurrence was recorded to the certification period of evidence the frequency nurse visits which occurred the frequency nurse visits which o	mellitus, included plans of on periods of 12-21-13 - 1 - 2 times a week and es a week), 2/19/14 - s a week and SN 1 times a 1/18/14 (SN one times a are for 2/19/14 - 4/19/14 by the physician. The in clinical record #15 with a date of 2/1/14 and estated, "D/C [discontinue] private duty assistance cluded the signature of			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		007377	B. WING		06/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
INCADE L	OME HEALTHCARE INC	425 S JOI	LIET ST STE 31	2	
INCARL	OME HEALTHOAKE INC	DYER, IN	46311		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
{N 524}	Continued From page	e 54	{N 524}		
		1:15 PM, Employee C			
	indicated the frequence	1:30 PM, Employee A cy and duration of skilled ncluded on the plan of care.			
	•	ve chronic bronchitis, re for the certification period This plan of care was not			
	On 6/3/14 at 2:15 the plan of care was r manner.	5 PM, Employee A indicated not signed in a timely			
	effective date stated, furnished under the sphysician. the plan of comprehensive assesprovided by the patier members The plan of the	ssment and information nt / family and health team			
	days An individualing physician shall be receiving home health services. The plan of	f care shall be completed in			
	all visits, services r procedures treatme orders will be reviewe and agency personne the patient's condition time every 60 days. If	frequency, and duration of medications, treatments, ent goals signed physician ed by the attending physician el as often as the severity of a requires, but at least one Professional staff alert the ages that suggest a need to			
	alter the plan of care.	Verbal telephone orders n the patient's physician for			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		СОМ	E SURVEY PLETED
		007377	B. WING			R-C 6/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
INCARE H	OME HEALTHCARE INC		OLIET ST STE 312 N 46311			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
{N 524}	Continued From page	e 55	{N 524}			
	changes in the plan of	of care."				
{N 527}	410 IAC 17-13-1(a)(2	2) Patient Care	{N 527}			
	promptly alert the per medical component of	The health care he home health agency shall rson responsible for the of the patient's care to any t a need to alter the medical				
	agency failed to ensu alerted the physician suggested a need to	ord review and interview, the ure the agency staff promptly to any changes that alter the plan of care for 1 of (#17) with the potential to				
	Findings					
	Nurse, indicated patic and then cut self on a Employee E, the hom update. The nurse d incident and did not v informal caregiver too	ere the patient was admitted				
		7, start of care 10/2/12, failed ician had been notified and self cutting.				
N 529	410 IAC 17-13-1(a)(2	2) Patient Care	N 529			
	Rule 13 Sec. 1(a)(2)	A written summary report				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
		007377	B. WING		06/03/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		425 S JOL	IET ST STE 312	2	
INCARE H	OME HEALTHCARE INC	DYER, IN	46311		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
N 529	Continued From page	e 56	N 529		
	for each patient shall (A) physician; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2)				
	agency failed to ensu were completed and every 60 days in 1 of of patients receiving s	ord review and interview, the re written summary reports sent to the physician at least 10 records (#16) reviewed services over 60 days to affect all the agency's			
	Findings				
	a diagnosis of bronch day summary had be	, start of care 10/23/13 and litis, failed to evidence a 60 en completed and sent to certification period ending			
		5 AM, the administrator ry had not been completed.			
{N 537}	410 IAC 17-14-1(a) S	scope of Services	{N 537}		
	provide nursing service	home health agency shall ces by a registered nurse or urse in accordance with the as follows:			
		t as evidenced by: ord and agency policy review ency failed to ensure skilled			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	007377		B. WING		R-C 06/03/2014	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
INCARE H	OME HEALTHCARE INC		IET ST STE 312	2		
		DYER, IN	46311 T			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET	TE
{N 537}	Continued From page	e 57	{N 537}			
	records reviewed (#7	sician's orders in 5 of 12 , 12, 13, 14, 16) creating the of the agency's patients that				
	with a diagnosis of Co included a plan of car of 3/23/14 - 5/21/14. AM failed to show tha orders on the plan of edema and periphera failed to complete a b	start of care (SOC) 7/26/13 ongestive Heart Failure, e for the certification period A nurse visit on 4/11/14 at 9 t the nurse had completed care including assessing for I circulation. The nurse ody system assessment e nurse failed to complete a				
		55 PM, Employee C, N) indicated the visits above n of care.				
	diagnosis of benign h plan of care for the ce - 6/19/14 on 5/29/14 a 10 AM, the clinical rec care for the certification 6/19/14. This plan of nurse was to visit the weeks to assess pain shortness of breath, we instruct on pain mana mechanics and safety proper foot wear whe encourage the patien	care evidenced the skilled patient 1 times a week for 9 level, instruction on veekly weights, assess and gement, proper body measures, to instruct on				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		007377	B. WING		R-C 06/03/	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
INCARE H	IOME HEALTHCARE INC	425 S JOLI DYER, IN	ET ST STE 31: 46311	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
{N 537}	indicated the plan of completed and was n and that skilled nurse record. b. On 5/29/14 at was observed to have with visit notes for the this paper. She indicated ocument the visit un was divided into about and the date were recorded indicate what part of the completed besides virtually assessments or instruction. c. On 6/3/14 at 2 that the skilled nurse record and document a visit note or in the sum of the sum of the completed besides virtually assessments. c. On 6/3/14 at 2 that the skilled nurse record and document a visit note or in the sum of the sum of the skilled nurse visits used by the skilled nurse visits policy. 3. Clinical record #13 plan of care for the construction of the construc	10:15 AM, Employee C care had not been of part of the clinical record visits were not in the 2:00 PM, Employee I, RN, as a blank piece of papers as past two months noted on ated that she did not til later at home. This paper at 8 sections and vital signs corded. The paper did not he plan of care had been tall signs. There was no pain actions for proper foot wear PM, Employee A indicated visits were missing from the ation of a visit should be on oftware program for skilled the agency. Employee A had not been documenting as timely or according to	{N 537}			
		urse had not followed the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R-C
		007377	B. WING		06/03/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
INCARE U	IOME HEALTHCARE INC	425 S JOI	LIET ST STE 31	2	
INCARE H	IOME HEALTHCARE INC	DYER, IN	46311		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
{N 537}	Continued From page	: 59	{N 537}		
	4. Clinical record #14 disruption evidenced occurred on 8/12/13 at The record evidenced certification period of was signed on 1/16/14 of care after this certifino orders for Skilled in documented on 2/18/ start of care assessmi 2/26/14. On 5/30/14 at 9:4 that there was no plan nurse visits that occur and the oasis start of completed by the RN 5. Clinical record #16 diagnosis of bronchitis nurse used triple antitipatient's skin tear on on 5/13/14 at 11:35 A where the skin tear was On 6/2/14 at 11:2 administrator, indicate this treatment. 6. The agency policy with no effective date services that are in coprofessional standard Industry as well as the identified agency perfistandards patient of the plan of care established.	with a diagnosis of wound two starts of care. One and the other on 2/26/14. If a plan of care for the 12/10/13 - 2/7/14, which were with an advice which were with an advice which were with an advice with a session period. There were with an advice which were with an advice which were with an advice with a session of the skilled and of care for the skilled and an advice with a session of the without obtaining an order witho			
	the plan of care estab	lished by a physician er services based on each			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		, , ,	(X3) DATE SURVEY COMPLETED	
			A. BUILDING.		_	
007377		B. WING			R-C /03/2014	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
INCARE	OME LIEAL THO A DE INIO	425 S JOI	LIET ST STE 312	2		
INCARE H	OME HEALTHCARE INC	DYER, IN	46311			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
{N 537}	Continued From page	e 60	{N 537}			
	effective date stated, furnished under the s physician. the plan or comprehensive assess provided by the patient members The plane reviewed to ensure the met, and updated as days An individualithe physician shall be receiving home health services. The plan of full to include type, all visits, services reprocedures treatme orders will be reviewed and agency personnet the patient's condition time every 60 days. It physician to any charalter the plan of care. shall be obtained from changes in the plan of care.	esment and information ont / family and health team an will be consistently at the patient needs are necessary at least every 60 zed plan of care signed by required for each patient on and personal care of care shall be completed in frequency, and duration of medications, treatments, and goals signed physician as often as the severity of on requires, but at least one professional staff alert the toges that suggest a need to Verbal telephone orders on the patient's physician for frequent's physician for freare."				
	nursing services will be Nurse or a Licensed F	ective date stated, "Skilled be provided by a Registered Practical / Vocational Nurse				
	in accordance with a Care [Physician's Ord whether a service req	uires the skills of a Nurse,				
	the inherent complexity of the service, condition of the patient, and accepted standards of medical and nursing practice will be considered The registered nurse a. Performs the initial assessment visit, b. Regularly reevaluates the patient needs, and coordinates necessary					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R-C
		007377	B. WING		06/03/2014
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA		
INCARE HOME HEALTHCARE INC DYER,			IET ST STE 31: 46311	2	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE
{N 537}	care and the care pla requiring specialized appropriate preventat nursing procedures e other personnel of ch	e plan of care and and updates to the plan of nd. Provides services nursing skill and initiates ive and rehabilitative.	{N 537}		
N 541	N 541 410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs.		N 541		
	and interview, the age registered nurse reev when the patient return admission in 1 of 12	ord and document review ency failed to ensure the aluated the patient's needs rned home from a hospital records reviewed creating all the patients who were			
	to evidence a comprebeen completed within discharge from the hotaling permacath. 2. A document titled System" and dated 2/	s, start of care 8/12/13, failed thensive assessment had a 48 hours of the patient's espital for treatment of a community Healthcare 21/14 evidenced the patient of from 2/21/14 - 2/23/14 for			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			_
		007377	B. WING		R-0 06/03	C 3/2014
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	-	
INCAREU	OME LIEAL TUCADE INC	425 S JOL	ET ST STE 312	2		
INCARE HOME HEALTHCARE INC DYER, II			46311			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
N 541	Continued From page	e 62	N 541			
	a failing permacath.					
	a raining pormadam.					
		S PM, Employee C indicated				
	•	discharged from the hospital ot been reevaluated when				
	he/she returned home					
N 545	410 IAC 17-14-1(a)(1)(F) Scope of Services	N 545			
	Rule 14 Sec. 1(a) (1)	(F) Except where services				
	are limited to therapy					
	nurse shall do the foll	health setting, the registered				
	(F) Coordinate service					
	This RULE is not me	<u> </u>				
		ord review, interview, and ency failed to ensure all				
		services documented the				
	coordination of care v	vhile services were being				
	·	ecords reviewed (12, 14, 15,				
		ith the potential to affect all ving more than one service.				
	agonoy patiente recei	iving more than one convice.				
	Findings:					
		50 AM, Employee C, the				
		ursing, indicated not sharing				
	any patients with other	er agencies.				
	2. Clinical record #12	2, start of care (SOC)				
	10/23/13 with a diagn	osis of benign hypertension,				
	·	re for the certification period				
		and services of home health nurse, and podiatrist. The				
		o show coordination of care				
		urse, the home health aide,				
	or the podiatrist.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPLETED
	007377 B.		B. WING		R-C 06/03/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
INCARE H	OME HEALTHCARE INC	425 S JOLI	ET ST STE 31:	2	
INCARE	OME HEALTHCARE INC	DYER, IN	16311		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
N 545	Continued From page	e 63	N 545		
	indicated no coordina	:15 AM, Employee C tion of care had occurred.			
		isruption, evidenced the dialysis services along with			
		. The clinical record failed			
	to evidence coordination of care with the dialysis facility and the skilled nurse.				
	being on home hemo completing this dialys	is at home three times a			
	_	o nocturnal hemodialysis in lity in December 2013.			
		telling the skilled nurse			
		red from a dialysis facility.			
	b. On 5/30/14 at 9:45 AM, Employee C indicated there was no coordination of care noted in the record between the skilled nurse and dialysis facility.				
	care for the certification	mellitus, included plans of on periods of 2/19/14 -			
	for 2/19/14 - 4/19/14	6/18/14. The plan of care was signed on 5/19/14 by ervices ordered were home			
	health aide and skille	d nurse services. This home health aide was to			
		c for 9 weeks for these The home health aide had			
	-	ent but had not turned in			
		December 2013. The are but the concern was not			
		nted. The record failed to			
	evidence coordination and home health aide	n between the skilled nurse e.			
			I		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	or contraction	IDENTI IOATION NOMBER.	A. BUILDING: _		OOWII EETEB
					R-C
007377		B. WING		06/03/2014	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
INOADE II	IOME HEALTHOADE IN	425 S JOL	LIET ST STE 312		
INCARE H	IOME HEALTHCARE INC	DYER, IN	46311		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
N 545	Continued From page	e 64	N 545		
		12:05 PM, Employee A was			
		Employee C and Employee A indicated Employee C			
	was sent to patient #1				
		as still caring for this patient			
		are. Employee A indicated			
		terminated earlier this year,			
		e of termination. Employee			
	_	ever reported this, I don't			
	know. There is a phy	sician order, but she			
		n the patient. This is under			
	_	consultant." Employee A			
		ee I, RN, is responsible for			
		cated that Employee I had			
		work with the agency but			
	still needed to make i				
		er care of the patients.			
		I that Employee I does			
		ealth aides well and was in			
		of this aide. The patient			
	was pleased with this	care from the agency.			
	b. On 5/29/14 at	4:30 PM, Employee R			
	indicated Employee S	S had resigned a couple of			
	months ago and that	no one from the agency had			
	seen her in the office	or at a visit with patient #15.			
	c. On 5/29/14 at	4:50 PM, Employee C			
	indicated visiting patie				
	weekend. Patient #1	5 was happy with the			
		and the aide. Employee C			
		nt in by Employee A to check			
		ployee S, HHA. Employee			
		ng that the Employee S had			
		new that no documentation			
		nonths from the Employee S			
	HHA's visits and she	<u> </u>			
		doing personal care for			
	·	ee C indicated the patient			
	∟was cognitively aware	e and indicated Employee S	1		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R-C
		007377	B. WING		06/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
INCARE H	IOME HEALTHCARE INC		IET ST STE 312	2	
	Г	DYER, IN	46311		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
N 545	Continued From page	: 65	N 545		
	was providing HHA se	ervices.			
	called via telephone a Employee C. She ind agency and caring for not turning in home he December 2013. She called her two weeks notes. This was the c agency. She indicate turned in the notes an trouble. e. A document in "Physician order" with physician signature st HHA - pt [patient] has since 12/13." This inc Employee A, administ F. Three docume home health aide care 12/18/13, 2/18/14, and 5. Clinical record #16 diagnosis of bronchitis	n clinical record #15 titled a date of 2/1/14 and no cated, "D/C [discontinue] private duty assistance cluded the signature of crator. The sents were evidenced to be the plans and were dated on data 4/18/14. SOC 10/23/13 and so, failed to evidence			
	a social work evaluati	services. Also an order for on on 4/21/14 evidenced the			
	refusal did not discuss order was refused and physician were aware	However, the order and sany details about how the difference of the refusal. The record ordination of care with the			
	licensed practical nurs	0:30 AM, Employee CC, se, indicated the patient was health agency that provided			

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STATE FORM 4C3X12 If continuation sheet 66 of 82

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
		A. BUILDING: _			
007377		007377	B. WING		R-C 06/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
INCARE H	IOME HEALTHCARE INC		IET ST STE 312	2	
		DYER, IN	46311		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
N 545	Continued From page	e 66	N 545		
	homemaker services.				
	indicated the patient h	I1:05 AM, the administrator nad refused social work as no other documentation			
	certification period of order on the plan of c order, 4/2/14, MSW [I eval [evaluation]" Thi signed by Employee A of nursing, and not signatient had a primary hypertension. The re	7, start of care 10/2/12 with a 4/3/14 - 6/1/14, included an are that stated, "Physician's Master's of Social Work] s was dated 4/2/14 and A, administrator and director gned by the physician. The diagnosis of benign cord failed to evidence between the social worker or			
	alternate administrato evaluation was not in	4:45 PM, Employee C, the or indicated the social work the record and that no care surred with the social worker			
	indicated the patient h worker. There was no communication to the	doctor or agency nurse all and need for the patient to			
	neoplasm, included a certification period of payment source was plan of care indicated skilled nurse visits 1 -	and diagnosis of brain plan of care for the			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDILAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMITE	ILD
		007377 B. WING			R-0 06/0	3/ 2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
INCARE H	OME HEALTHCARE INC	425 S JOL	IET ST STE 31	2		
		DYER, IN	46311	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
N 545	Continued From page	e 67	N 545			
	2 times a week for 9 v HHA visits documented 4/9/14, 4/11/14, 4/16/4/24/14 after the disconsumented was an aide care plar no tasks for the home. On 6/3/14 at 7:45 not knowing he / she the home health ager not being aware of the certification per and payment source are cord were HHA visit name of patient #21 of this plan of care was of 1 time week for 9 weeks. H4/2/14, 4/4/14, 4/8/14, 4/25/14, 4/25/14, 4/25/14, 4/25/14, 4/10/14, 4/10/	weeks. There were also ed for 3/25/14, 4/3/14, 14, 4/18/14, 4/22/14, and harge of this patient. There in dated on 1/30/14 that had e health aide to complete. 5 AM, patient #21 indicated was receiving services from any. Patient #21 indicated sing discharged. There was on that showed the patient in the record.				
	registered nurse, indi- the only one of patien home health aide sen were used for patient	10:25 AM, Employee W, cated that patient #22 was ats #21 and #22 receiving vices. Patient #21's visits #22. Employee W indicated urse visiting patient #22 and rvision. There was no				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
				,	R-C	
		007377	B. WING			/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE		
INCARE H	OME HEALTHCARE INC		LIET ST STE 312			
		DYER, IN	46311			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
N 545	Continued From page	e 68	N 545			
	documentation of car record between the s	e communication in the ervices.				
	indicated that she wa with patients #21 and	:05 PM, the administrator s looking into this situation #22. She stated, "We are is. [The patient] has private				
	Patient services" with personnel furnishing silaison to assure that effectively and support the Plan of Care. This formal care conference current Care plans are interaction Interdisciplated as respond to changes in services, care, or goal	ciplinary care conferences s often as necessary to n the patient's needs, als Ongoing care conducted to evaluate the				
	Services" with no effective registered nurse a. F	Regularly reevaluates the				
{N 546}	410 IAC 17-14-1(a)(1)(G) Scope of Services	{N 546}			
	are limited to therapy practice in the home nurse shall do the foll (G) Inform the physic	health setting, the registered				

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STATE FORM 6899 4C3X12 If continuation sheet 69 of 82

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R-C
		007377	B. WING		06/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
INCARE H	IOME HEALTHCARE INC	425 S JOI DYER, IN	LIET ST STE 312 46311	2	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
{N 546}	family in meeting nurs	counsel the patient and sing and related needs, e programs, and supervise	{N 546}		
	agency failed to ensu alerted the physician suggested a need to	ord review and interview, the re the agency staff promptly to any changes that alter the plan of care for 1 of #17) with the potential to			
	Nurse, indicated patie and then cut self on a Employee E, the hom update. The nurse di incident and did not w informal caregiver too emergency room whe and stayed several da 2. Clinical record #17	re the patient was admitted ays. 7, start of care 10/2/12, failed cian had been notified			
N 596	be responsible for encontact, the individual aide services on its boof this section as follo (1) The home health	e home health agency shall suring that, prior to patient is who furnish home health ehalf meet the requirements ws:	N 596		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BUILDING: _		R-C	
		007377	B. WING		06/03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
INCARE H	OME HEALTHCARE INC		LIET ST STE 312	2	
0/0/15	QUIMMADV QT/	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	N O(E)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
N 596	Continued From page	70	N 596		
		at addresses each of the section (h) of this rule; and			
	interview, the agency health aide had comp evaluation prior to furn home health aide files	ile and policy review and failed to ensure the home leted a competency nishing services in 1 of 2 serviewed (U) with the he patients that receive aide			
	Findings				
	4/9/09 and first patien	e Health Aide, date of hire t contact in 2009, failed to skills evaluation had been			
	services" with no effect	titled "Home Health Aide ctive date stated, "Only no meet required standards e."			
	3. On 5/29/14 at 12:2 indicated the personn complete.	11 PM, Employee C, RN, el records were not			
{N 606}	410 IAC 17-14-1(n) S	cope of Services	{N 606}		
	in therapy only cases, the patient's residence visit at least every thir the home health aide	egistered nurse, or therapist shall make the initial visit to e and make a supervisory ty (30) days, either when is present or absent, to essess relationships, and to eals are being met.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BOILBING.		D C	
		007377	B. WING		R-C 06/03/2014
NAME OF PROVIDE	FR OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE	
TWINE OF TROVIDE	IN ON OO! I EIEN		LIET ST STE 31	, and the second	
INCARE HOME	HEALTHCARE INC	DYER, IN		_	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETE
This Base ager mad least paties aide affect skilled. Find 1. Coaide a wee of 4/ provereco beer regis. Regis note 2. Cl a dia care 2-18 skilled 4/19 weel was how had 2013 conditions.	ed on clinical recording failed to ensure a supervisory of tevery 30 days in ents (#12 and #15 and skilled servict all of the agence and home heatings Clinical record #12 (HHA) services If the ent of the ent	ord review and interview, the pare the registered nurse had risit to the patient's home at a 2 of 9 records reviewed of 5) that received home health ces creating the potential to by's patients that receive alth aide services. 2 evidenced home health had been ordered 1- 2 times aring the certification period and skilled nurse had been a week for 9 weeks. The ten osupervisory visits had a week for 9 weeks. The ten osupervisory visits had with the certification period and skilled nurse had been a week for 9 weeks. The ten osupervisory visits had with the certification period and skilled nurse had been a week for 9 weeks. The ten osupervisory visits had with the certification period and skilled nurse had been a week for 9 weeks. The ten osupervisory visits had with the certification period and skilled nurse had been a week for 9 weeks. The ten osupervisory visits had with the certification period and skilled nurse had been a week for 9 weeks. The ten osupervisory visits had with the certification period and skilled nurse had been a week for 9 weeks. The ten osupervisory visits had with the certification period and skilled nurse had been a week for 9 weeks. The ten osupervisory visits had with the certification period and skilled nurse had been a week for 9 weeks. The ten osupervisory visits had with the certification period and skilled nurse had been a week for 9 weeks.	{N 606}		

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	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	CONSTRUCTION		SURVEY PLETED
		007377	B. WING			R-C 5/ 03/2014
					1 00	703/2014
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE		
INCARE H	IOME HEALTHCARE INC		LIET ST STE 312			
		DYER, IN	46311			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
{N 606}	Continued From page	e 72	{N 606}			
	record. The registere these visits during this	ed nurse had not supervised s time.				
	administrator, was ca Employee C and Emp A indicated that Empl #15's home to check still caring for this pat care. Employee A ind terminated earlier this date of termination. It she never reported the physician order, but so the patient. This is un consultant." Employe I, Registered Nurse, i Employee A indicated progress in her work needs to make impro- with her care of the p indicated that Employ home health aides we supervision of this aid had not looked at any	oloyee R present. Employee oyee C was sent to patient if Employee S, HHA, was ient under the agency's dicated that Employee S had s year, but did not give a Employee A stated, "Why his, I don't know. There is a she maintains contact with onder investigation with our ee A indicated that Employee s responsible for this. If that Employee I has made with the agency but still vement with documentation				
	indicated Employee S months ago and that	4:30 PM, Employee R S had resigned a couple of no one from the agency had or at a visit with patient #15.				
	indicated visiting patie weekend. Patient #1 services from Incare indicated that she wa check on the services	•				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BOILDING.		R-C	
		007377	B. WING		1	3/2014
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
INCARE H	OME HEALTHCARE INC		ET ST STE 312	2		
	OUNDAMEN OF	DYER, IN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
{N 606}	Continued From page	e 73	{N 606}			
	Employee S HHA's vi investigate if Employee care for patient #15. patient was cognitivel Employee S was proved. On 5/30/14 at called via telephone as Employee C. She incagency and caring for not turning in home he December 2013. She called her two weeks notes. This was the composition of the care of the c	seen sent in for months from sits and she was to see S was still doing personal Employee C indicated the y aware and indicated viding HHA services. 11:55 AM, Employee S and spoke to writer and dicated still working for the repatient #15. She indicated ealth aide visit notes since indicated Employee A ago telling her to turn in her only patient she saw for the d she was sorry she had not				
	titled "Physician order no physician signature HHA - pt [patient] has	ument in clinical record #15 " with a date of 2/1/14 and e stated, "D/C [discontinue] private duty assistance luded the signature of trator.				
{N 608}	410 IAC 17-15-1(a)(1	-6) Clinical Records	{N 608}			
	pertinent past and cur with accepted profess maintained for every p (1) The medical plan identifying informatio (2) Name of the phy podiatrist, or optometr (3) Drug, dietary, tree	n of care and appropriate n. ⁄sician, dentist, chiropractor,				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE COMP	SURVEY LETED
		007377	B. WING		l l	R-C (03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE	·	
INCARE H	IOME HEALTHCARE INC		LIET ST STE 312			
		DYER, IN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
{N 608}	Continued From page	2 74	{N 608}			
	be written the day ser incorporated within fo (5) Copies of summ person responsible for the patient's care. (6) A discharge sum This RULE is not me Based on clinical record document and policy review, and interview, ensure 7 of 12 clinica - #18, #21, #22) review maintained according	urteen (14) days. ary reports sent to the ir the medical component of inmary. It as evidenced by: ord review, agency review, other document it the administrator failed to Il records (clinical record #14 ewed were accurate and				
	The findings include:					
	Regarding clinical rec	ord #14				
	services had been profor 9 weeks during the 12/10/13 - 2/7/14 and 2/18/14 and 3/7/14. The transferred to the hos home on 2/23/14. Note had occurred to show discharged and then a occurred when the part However, an oasis state completed by the RN kept as a closed records, but failed to a assessment or summer to 2/7/10/10/10/10/10/10/10/10/10/10/10/10/10/	pital on 2/2/14 and returned wither a transfer or discharge that the patient had been no resumption of care had attent returned home. That of care assessment was on 2/26/14. The record was red in a file cabinet for closed show that any discharge ary had occurred or that a securred. It was not known				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		007377	B. WING		R-C 06/03/2014
NAME OF S			DDESS OFF OF	TE ZID CODE	1 00/00/2014
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA		
INCARE F	IOME HEALTHCARE INC	DYER, IN	.IET ST STE 312 .46311	2	
04.0.1=	CHMMADV CT	<u> </u>		DDOV/DEDIS DI ANI OF CODDECTIO	N OVE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
{N 608}	Continued From page	e 75	{N 608}		
	a. A document ti System and dated 2/2 had been hospitalized a failing permacath. b. On 5/28/14 at that services stopped	tled "Community Healthcare 21/14 evidenced the patient d from 2/21/14 - 2/23/14 for 7 PM, patient #14 indicated and that he / she had not			
	c. On 5/30/14 at indicated no hospital had been completed a This was not following indicated the patient had had signed conse 2/26/14 and had beer There were no orders care provided. d. On 5/30/14 at indicated that the patifrom the services of the discharge OASIS asset	9:10 AM, Employee C transfer or discharge oasis at patient #14's end of care. g policy. Employee C nad signed the patient rights ent for a new start of care on n visited by the skilled nurse. s and no plan of care for this 2:26 PM, Employee C tent had been discharged the agency and there was no the same of the sessment or discharge thad been transferred to			
	the hospital on 2/21/1 2/23/14. There was record #15 and a diagnosis of diaplans of care for the conduction of care for 2/19/14 - 4/19/14 and of care for 2/19/14 by the physic the home health aide week for 9 weeks for The home health aide	3 and returned home on no resumption of care. cord #15 , start of care (SOC) 8/23/13 abetes mellitus, included			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		007377	B. WING			R-C 6/ 03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
INCARE H	OME HEALTHCARE INC		OLIET ST STE 312 N 46311			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
{N 608}	but the concern was documented. a. On 5/29/14 at called by phone with R present. Employe C was sent to patient Employee S, home had caring for this patient Employee A indicate terminated earlier this date of termination. She never reported the physician order, but the patient. This is used to make improved the patient. This is used to make improved to make imp	e administrator was aware not corrected or 12:05 PM, Employee A was Employee C and Employee e A indicated that Employee t #15's home to check if realth aide (HHA), was still to under the agency care. It is is placed to that Employee A stated, "Why is, I don't know. There is a she maintains contact with under investigation with our ee A indicated that Employee RN), is responsible for this. It is that Employee I has made with the agency but still evement with documentation existents. Employee A yee I does supervise the ell and was in charge of de. The patient is pleased to agency. 4:30 PM, Employee R S had resigned a couple of no one from the agency had a or at a visit with patient #15. 4:50 PM, Employee C ent #15 over the past 5 was happy with the and the aide. Employee C as sent in by Employee A to s of an Employee S, HHA. It is that Employee C as sent in by Employee S, HHA. It is that Employee C as sent in by Employee S, HHA. It is that Employee C as sent in by Employee S, HHA. It is that Employee C as sent in by Employee S, HHA. It is that Employee C as sent in by Employee S, HHA. It is that Employee C as sent in by Employee S, HHA. It is that Employee C as sent in by Employee S, HHA. It is that Employee C as sent in by Employee S, HHA. It is that Employee C as the Employee S, HHA. It is that Employee C as the Employee S, HHA. It is that Employee C as the Employee S, HHA. It is that Employee C as the Employee S, HHA. It is that Employee C as the Employee S, HHA. It is that Employee C as the Employee S and the Employee C as the Employee S and the Employee C as the Employee S and the Em	{N 608}			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLET	RVEY TED
R-C	
007377 B. WING 06/03/	/2014
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
INCARE HOME HEALTHCARE INC 425 S JOLIET ST STE 312 DYER, IN 46311	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(N 608) Continued From page 77 documentation had been sent in for months from Employee S HHA's visits and she was to investigate if Employee S was still doing personal care for patient #15. Employee C indicated the patient was cognitively aware and indicated Employee S was providing HHA services. d. On 5/30/14 at 11:55 AM, Employee S called via telephone and spoke to writer and Employee C. She indicated still working for the agency and caring for patient #15. She indicated not turning in home health aide visit notes since December 2013. She indicated Employee A called her two weeks ago telling her to turn in her notes. This was the only patient she saw for the agency. She indicated she was sorry she had not turned in the notes and asked if she was in trouble. e. A clinical document in clinical record #15 titled "Physician order" with a date of 2/1/14 and no physician signature stated, "D/C [discontinue] HHA - pt [patient] has private duty assistance since 12/13." This included the signature of Employee A, administrator. f. Three clinical documents were evidenced to be home health aide care plans and were dated on 12/18/13, 2/18/14, and 4/18/14. Regarding clinical record #16 3. Clinical record #16 3. Clinical record #16, SOC 10/23/13 and a diagnosis of bronchitis, included a plan of care for the certification period of 4/21/14 - 6/19/14 evidenced an active record. However, the patient had been transferred on 5/16/14 and then	

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1NCARE HOME HEALTHCARE INC 1NCARE HOME HEALTHCARE INC STREET ADDRESS, CITY, STATE, ZIP CODE 425 S JOLIET ST STE 312 DYER, IN 46311 (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)	DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE INCARE HOME HEALTHCARE INC	A. BUILDING:	
INCARE HOME HEALTHCARE INC A25 S JOLIET ST STE 312 DYER, IN 46311 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (N 608) Continued From page 78 record was closed. a. A document titled "Incare Home Healthcare, inc. Patient Survey Census" with an effective date of 5/28/14 included patient #16's	007377 B. WING	I
INCARE HOME HEALTHCARE INC DYER, IN 46311 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) {N 608} Continued From page 78 record was closed. a. A document titled "Incare Home Healthcare, inc. Patient Survey Census" with an effective date of 5/28/14 included patient #16's	/IDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (N 608) Continued From page 78 record was closed. a. A document titled "Incare Home Healthcare, inc. Patient Survey Census" with an effective date of 5/28/14 included patient #16's (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIV	NE HEALTHCARE INC	
record was closed. a. A document titled "Incare Home Healthcare, inc. Patient Survey Census" with an effective date of 5/28/14 included patient #16's	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE AC REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO	CTION SHOULD BE COMPLETE DATE DATE
10/23/13 and certification period of 4/21/14 - 6/19/14, diagnosis of bronchitis, and disciplines of skilled nursing and home health aide. b. On 6/2/14 at 10:25 AM, Employee A indicated the discharge was pending in the computer software program called AXXESS, since she was still learning features of the program. Regarding clinical record #17 4. A document titled "Incare Home Healthcare, inc. Patient Survey Census" with an effective date of 5/28/14 included patient #17's name, medicare #, date of birth, SOC date as 2/2/14 and certification period of 4/3/14 - 6/1/14, diagnosis of benign hypertension, and disciplines of skilled nursing and home health aide. a. On 5/29/14 at 12:15 PM, Employee C, the alternate administrator, was unable to find patient #17's record. b. On 5/30/14 at 11:40 AM and at 1:10 PM, Employee C was unable to find patient #17's record. c. On 5/30/14 at 4 PM, the owner of the agency, Employee R, found the clinical record in the discharged records. The patient's last home health aide visit had occurred on 4/29/14 and the	a. A document titled "Incare Home ealthcare, inc. Patient Survey Census" with an fective date of 5/28/14 included patient #16's ame, medicare #, date of birth, SOC date as 0/23/13 and certification period of 4/21/14 - 19/14, diagnosis of bronchitis, and disciplines of killed nursing and home health aide. b. On 6/2/14 at 10:25 AM, Employee A dicated the discharge was pending in the computer software program called AXXESS, noce she was still learning features of the rogram. egarding clinical record #17 A document titled "Incare Home Healthcare, c. Patient Survey Census" with an effective date 15/28/14 included patient #17's name, medicare date of birth, SOC date as 2/2/14 and ertification period of 4/3/14 - 6/1/14, diagnosis of enigh hypertension, and disciplines of skilled ursing and home health aide. a. On 5/29/14 at 12:15 PM, Employee C, the ternate administrator, was unable to find patient 17's record. b. On 5/30/14 at 11:40 AM and at 1:10 PM, mployee C was unable to find patient #17's record. c. On 5/30/14 at 4 PM, the owner of the gency, Employee R, found the clinical record in the discharged records. The patient's last home	

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		007377	B. WING		I	R-C 6/ 03/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
INCARE E	OME HEALTHCARE INC	425 S J	OLIET ST STE 312			
HOARET	TOME HEALTHOAKE INC	DYER, II	N 46311			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
{N 608}	Continued From page	e 79	{N 608}			
	that date. There was oasis documentation record. d. On 5/30/14 at Registered Nurse, incorransferred to the hos now discharged. No assessment or summ e. On 6/3/14 at 1 administrator, indicate	no transfer or discharge evidenced in the clinical 4:30 PM, Employee I, dicated the patient had been pital on 4/29/14 and was transfer oasis or discharge ary had been completed. :35 PM, Employee A, the				
		cord #18 PM, Employee C indicated ord was not able to be				
	record was located wi and assessment. b. On 6/2/14 at 1	2:20 PM, Patient #18's ith a discharge summary 2:20 PM, the administrator s record was complete.				
	Regarding Clinical red	cords #21 and #22				
	neoplasm, included a certification period of payment source was plan of care indicated skilled nurse (SN) visi	and diagnosis of brain plan of care for the				

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INCARE HOME HEALTHCARE INC 128 SUMMANY STATEMENT OF DEPICENCIES PRETEX TAG PROVIDER'S PLAN OF CORRECTION PRETEX TAG PROVIDER'S PLAN OF CORRECTION PAGE TO AG PRETEX TAG PRETEX TAG PRETEX TAG PROVIDER'S PLAN OF CORRECTION PAGE TO AG PRETEX TAG PRETEX TAG PROVIDER'S PLAN OF CORRECTION PAGE TO AG PRETEX TAG PRETEX TAG PROVIDER'S PLAN OF CORRECTION PAGE TO AG PRETEX TAG PRETEX TAG PRETEX TAG PROVIDER'S PLAN OF CORRECTION PAGE TAG PRETEX TAG PROVIDER'S PLAN OF CORRECTION PAGE TAG PRETEX TAG PRETEX TAG PROVIDER'S PLAN OF CORRECTIO		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER INCARE HOME HEALTHCARE INC INCARE HOME HEALTHCARE HOME HEALTHCARE HOME HOME HOME TAGGET HE HAD BEEN THE CROSS REFERENCED TO PINE APPROPRIANT. INCARE HOME HEALTHCARE HOME HEALTHCARE HOME HOME HOME HOME HOME HOME HOME HOM			007377				_
INCARE HOME HEALTHCARE INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG TAG REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG (R 608) Continued From page 80 showers 1 - 2 times a week for 9 weeks. (Interviews with staff and the informal caregiver and the patient indicated that the patient received no personal care from the HHA-8 through this time.) There were also HHA visits documented for 37/25/14, 47/31/4, 49/14, 41/11/4, 41/61/4, 41/81/4, 42/21/4, and 47/24/14 after the discharge of this patient. There was an aide care plan dated on 1/30/14 that had no tasks for the home health aide to complete. 7. Clinical record #22, SOC 10/1/13 and a diagnosis of paraplegia, included a plan of care for the certification period of 3/30/14 - 5/28/14 and payment source as Medicare. Included in the record were HHA visits from record #21 with the name of patient #21 documented. Ordered on this plan of care were the SN frequency of 1 time per week for 9 weeks and HHA 2 times a week for 9 weeks. HHA visits occurred on 3/25/14, 4/29	NAME OF B			DDEEC CITY CTATE	ZID CODE	1 00	003/2014
CAST Companies Cast Ca	NAME OF P	ROVIDER OR SUPPLIER			E, ZIP CODE		
(N 608) Continued From page 80 showers 1 - 2 times a week for 9 weeks. (Interviews with staff and the informal caregiver and the patient indicated that the patient received no personal care from the HHAs through this time.) There were also HHA visits documented for 3/25/14, 4/3/14, 4/9/14, 4/11/14, 4/16/14, 4/18/14, and 4/24/14 after the discharge of this patient. There was an aide care plan dated on 1/30/14 that had no tasks for the home health aide to complete. 7. Clinical record #22, SOC 10/1/13 and a diagnosis of paraplegia, included a plan of care for the eHHA visits form record #21 with the name of patient #21 documented. Ordered on this plan of care were the SN frequency of 1 time per week for 9 weeks. HHA visits occurred on 4/2/14, 4/4/14, 4/8/14, 4/10/14, 4/15/14, 4/17/14, 4/15/14,	INCARE H	HOME HEALTHCARE INC					
showers 1 - 2 times a week for 9 weeks. (Interviews with staff and the informal caregiver and the patient indicated that the patient received no personal care from the HHAs through this time.) There were also HHA visits documented for 3/25/14, 4/3/14, 4/9/14, 4/16/14, 4/18/14, 4/22/14, and 4/24/14 after the discharge of this patient. There was an aide care plan dated on 1/30/14 that had no tasks for the home health aide to complete. 7. Clinical record #22, SOC 10/1/13 and a diagnosis of paraplegia, included a plan of care for the certification period of 3/30/14 - 5/28/14 and payment source as Medicare. Included in the record were HHA visits from record #21 with the name of patient #21 documented. Ordered on this plan of care were the SN frequency of 1 time per week for 9 weeks. and HHA 2 times a week for 9 weeks. HAHA visits occurred on 4/2/14, 4/4/14, 4/8/14, 4/10/14, 4/15/14, 4/17/14, 5/13/14, and 5/15/14. SN visits occurred on 3/25/14, 4/29/14, 4/30/14, 5/17/14, 5/13/14, and 5/15/14. SN visits occurred on 3/25/14, 4/10/14, 4/35/14, 4/30/14, 5/7/14, 5/14/14, and 5/21/14. HAHA visits occurred on 3/25/14, 4/10/14, 4/22/14, 4/24/14, 4/30/14, 5/17/14, 5/14/14, and 5/21/14. HAHA visits documented as to patient #21 were also in this record. These were from the following dates: 4/9/14, 4/11/14, 4/18/14, 4/18/14, 4/22/14, 4/24/14, 4/30/14, and 5/2/14. On 6/3/14 at 1:05 PM, the administrator indicated that she was looking into this situation with patients #21 and #22. She stated, "We are not benefiting from this. [The patient] has private	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF	HOULD BE	COMPLETE
8. The agency policy titled "Clinical documentation" with no effective date stated, "Agency will document each direct contact with	{N 608}	showers 1 - 2 times at (Interviews with staff and the patient indica no personal care fron time.) There were als for 3/25/14, 4/3/14, 4/4/18/14, 4/22/14, and of this patient. There on 1/30/14 that had naide to complete. 7. Clinical record #22 diagnosis of paraples for the certification peand payment source record were HHA visi name of patient #21 of this plan of care were per week for 9 weeks for 9 weeks. HHA vi 4/4/14, 4/8/14, 4/10/14, 4/25/14, 4/29/14, 4/30 5/13/14, and 5/15/14. 3/25/14, 4/10/14, 4/25/14/14, and 5/21/14. to patient #21 were a were from the followin 4/16/14, 4/18/14, 4/25/2/14. On 6/3/14 at 1:00 indicated that she was with patients #21 and not benefiting from the pay." 8. The agency policy documentation" with	and the informal caregiver ated that the patient received in the HHAs through this so HHA visits documented (9)/14, 4/11/14, 4/16/14, 14/24/14 after the discharge was an aide care plan dated to tasks for the home health (14), 3/14, 3/14, 3/14, 3/14, 5/14, 4/15/14, 4/17/14, 4/15/14, 4/17/14, 4/15/14, 4/17/14, 4/17/14, 4/15/14, 4/17/14, 4/17/14, 4/15/14, 4/17/14, 5/9/14, 5/11/14, 5/7/14, 5/9/14, 5/11/14, 5/11/14, 4/17/14, 4/	{N 608}			

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	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			-		R-C
		007377	B. WING		06/03/2014
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
INCARE H	IOME HEALTHCARE INC	425 S JOLI DYER, IN	IET ST STE 31: 46311	2	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED (ENCY)	D BE COMPLETE
{N 608}	completed by the dire by the skilled professi managing the patient there is an accurate reprovided, patient resp care to document of care, modifications to interdisciplinary involving the services ordered of completed the day se incorporated into the after the care has been stated, "Clinical records."	act caregivers and monitored ional responsible for its care to ensure that ecord of the services ionse and ongoing need for conformance with the plan of the plan, and iverent documentation of ion the plan of care will be rivice is rendered and clinical record within 7 days en provided." titled "Clinical records / intion" and no effective date rid [is] A confidential clinical tinent past and current e with professional ed for every patient	{N 608}		

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